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ABSTRACT

This document consists of papers by masters degree students that concern counseling techniques for at-risk youth. The following papers included are: (1) "Adolescent Depression: Its Diagnosis and Treatment" (Bruce Bowers); (2) "Counseling the Bereaved Child: A School Counselor's Perspective" (David Boyle); (3) "Adolescents of Divorce: An Overview for School Counselors" (Jean Coldsmith); (4) "Counseling Children with an Over-Anxious Disorder" (Karla Kerstner); (5) "School Counselor's Role in Drug Education Programs" (Sandy Lemmon); (6) "Learning Disabilities and Counseling Interventions" (Cindy Parke); (7) "Children of Divorce: An Intervention Program for Elementary Schools" (Christie M. Plinski); (8) "The Dropout and the Counselor: Hope for the Future" (Vicki Thomas); (9) "Bereavement of Adolescents Following the Suicide of a Friend" (Gail R. Winden); and (10) "Use of Behavioral Techniques in Controlling Stealing Behaviors in Children" (Donna Aratani). Each paper includes an abstract and references. (TE)

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AT-RISK YOUTH

A Compilation of Counseling Technique Papers

Developed by
Oregon State University College of Education
Department of Counseling
Master's Degree Students

CG022747

Edited by
Lizbeth A. Gray, MSW, Ph.D., NCC
Associate Professor

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ADOLESCENT DEPRESSION:
Its Diagnosis and Treatment

by

Bruce Bowers
Oregon State University
Department of Counseling

ABSTRACT

This paper raises the question of the nature and extent of depression among adolescents. Of the two forms of depression recognized in the clinical literature -- uni-polar and bi-polar -- only the unipolar form is recognized as a significant phenomenon among adolescents. There now exists a range of instruments designed specifically to assess the existence and intensity of adolescent depression. Depending on which instruments are used, and whether one is interested in current or historical episodes, estimates of the prevalence of depression among adolescents vary widely. The most commonly cited treatment models are either cognitively or behaviorly oriented. Treatment effects are generally significant in comparison to wait-list controls, but no one treatment approach stands out as clearly superior. Current treatment models may be too narrow in their approach, because they do not take into account significant gender differences in the nature of adolescent depression, nor do they focus sufficiently on factors within the depressed adolescent's social network that may be operating to perpetuate the depression.

Adolescence is traditionally viewed to be a time of emotional turmoil, a period when abnormal moods and behavior are often considered normal. From the adolescent's perspective this attitude can be a mixed blessing. It functions to give greater leeway to the adolescent to act out his or her frustrations, to give vent to rebellious inclinations, in short, to begin the transition from childhood to adulthood. At the same time, however, such a view may minimize the severity of adolescent upheavals, by assuming that they are only a passing phase, to be cured by the simple passage of time. As a result an adolescent's very real needs for support and even therapy may be ignored.

This paper focuses upon just one potential feature in the emotional life of the adolescent -- depression. The position taken here is that, while normal mood swings often include brief periods of mild depression, a significant minority of adolescents may be exhibiting more intense and longer lasting depressive symptoms, requiring therapeutic attention. The question explored is, how are such adolescents to be identified and what sorts of therapeutic treatment are recommended?

Preliminary Definitions

Adolescence usually refers to the prepubertal and pubertal years, which, on the average, ranges from about the tenth to the eighteenth year. Studies referred to in this paper will be from this range unless otherwise noted. The term depression in this paper refers only to what is known in the psychiatric literature as uni-polar depression. That is, the discussion will not concern itself with bi-polar depression, a form which is usually preceded or followed by a manic phase and which is almost non-existent among adolescents (Carlson, 1983). There is no universally agreed-upon definition of uni-polar depresssion; rather there are many different theoretical approaches. Further, there is a plethora of instruments designed to assess the nature and intensity of depression at all age levels.

Assessment

The most well established, but also the most time-consuming, method for assessing depression in adolescents comes from the clinical psychology perspective. The instrument used is called the Schedule for Affective Disorders and Schizophrenia for School-Aged Children or the Kiddie-SADS (Puig-Antich & Chambers, 1978). This is an adaptation of a similar assessment instrument that has been used for years in the clinical assessment of adults. It is not a cost-efficient method of assessment since it involves rather lengthy interviews not only with the adolescent but also with the parent. Its purpose is to determine whether the adolescent fits any of the criteria for affective disorders and schizophrenia found in the Diagnostic and Statistical Manual III-R (American Psychiatric Association, 1987), referred to as the DSM-III-R criteria. These criteria are the most widely adopted among clinicians in the United States, and it is largely through correlations with these criteria that other faster, more cost-efficient instruments have been validated. A condensed listing of symptoms related to the DSM-III-R criteria for child and adolescent depression, prepared by Matson (1989), is presented in Table A-1.

A more cost-efficient, but less accurate, approach to the assessment of depression in adolescents is the use of checklists or scales. The most popular of these is the Child Depression Inventory (CDI) which is based upon the Beck Depression Inventory for adults, and which can be used for children and adolescents in the 7 to 17 year age range. The items in this inventory which correlate with depression are presented in Table A-2 (Helsel & Matson, 1984). The CDI has been researched more thoroughly than any of the other checklists or scales and has been found to be a valid and reliable instrument. Other similar instruments now in use are the Reynolds Adolescent Depression Scale, the Children's Depression Scale, Children's Depression Rating Scale, the Children's Depression Adjective Checklist, and the Depression Self-Rating Scale (Matson, 1989).

Extreme depression is usually a precipitating factor in most suicides and suicide attempts. Yet not all types of depression seem conducive to the suicide attempt. Kazdin, Rodgers, and Colbus (1986) have developed a measure, the Hopelessness Scale for Children, based on their analysis of items from more general depression scales. They found that items reflecting a hopeless attitude about the future were highly correlated with suicide attempts. The items on this scale are presented in Table A-3.

Another area receiving some attention is the correlation between depression and lack of social skills. Helsel and Matson (1984), using a scale called the Matson Evaluation of Social Skills with Youngsters (MESSY) found that there was a high correlation between scores on the CDI and MESSY. This finding suggests a basis for a social skills training approach to the treatment of adolescent depression.

In general, one's approach to the assessment of adolescent depression depends upon the purposes of the assessment. If one is attempting simply to attain a ballpark notion of the prevalence of depression among a group of adolescents, say, for the purpose of establishing a relevant agenda in a school-based therapy group, then perhaps the CDI alone is sufficient. If, however, one is intent upon determining, prior to treatment, the specific parameters of a particular youngster's affective dysfunction, then a much more thorough assessment is in order. It may be that a dramatic score on the CDI would trigger a greater focus on the youngster. At this point it might be appropriate to administer the more time-consuming Kiddie-SADS interview in order to obtain a more in-depth picture of that youngster's depressive symptoms and to probe for other related conditions.

Prevalence

The question of the prevalence of uni-polar depression goes hand in hand with the question of how it is assessed. For example, some commentators from the traditional psychoanalytic school of thought argue that true depression is nonexistent in children and adolescents due to the as-yet-undeveloped super ego in that age group (Rie, 1966, cited in Lewinsohn, Hops, Roberts & Seeley, 1989). Others suggest that the standard adult symptoms of depression are masked in adolescents by "hyperactivity, aggressiveness, school failure, delinquency and psychosomatic symptoms" (Cytryn & McKnew, 1974, p. 880). However, use of the assessment instruments mentioned above have yielded some estimates of the prevalence of depression among young people.

Sullivan and Engin (1986) gave estimates of the prevalence of depression among 103 high school students in a urban South Carolina school based upon the Beck Depression Inventory. Their results indicated that 26% of the sample were moderately depressed and 6% were severely depressed. In a more recent and much larger study, Lewinsohn, Hops, Roberts, and Seeley (1990) estimated the "point prevalence" (currently depressed) and "lifetime prevalence" (depressed for at least one period in the past) of depression among 1708 high school students. Using a more exhaustive set of assessment instruments, culminating in the Kiddie-SADS, they estimated that 3% of the sample were currently clinically depressed, while 22% had experienced clinical depression at least once in their lives.

Whatever estimates one accepts as valid, it is clear that, unless one uses a theoretical framework that defines adolescent depression out of existence, there is a significant minority of adolescents who suffer from depression severe enough to merit therapeutic attention.

Treatment

One major model for explaining depression is the cognitive model, first put forward by Beck (1967). According to this model, depression results from cognitive distortions, which produce negative perceptions of self, the current personal situation, and the future. This negative bias is maintained via cognitive schema, or fixed patterns of thinking, established through previous negative experiences. In essence, the depressive reconstructs his or her reality in negative terms.

From the cognitive point of view, depressive affect, while very real, is only the symptom, not the root, of the depression. It is the distorted negative cognitions which are more fundamental. These are treated by first getting the client to identify his or her cognitive distortions and confronting them with the evidence of objective experience.

A variation on the cognitive approach has been suggested by Rehm (1977). This model views depression as a set of related problems in self-control. The depressed person suffers deficits in self-monitoring, self-evaluation, and self-reinforcement. In the self-monitoring manifestation, "depressed persons tend to attend selectively to negative events and to immediate versus delayed outcomes of their behavior" (p. 792). In the self-evaluation manifestation, "depressed persons frequently fail to make accurate internal attributions of causality and...to set stringent criteria for self-evaluation" (p. 793). In the self-reinforcement manifestation, "depression can be characterized by the self-administration of relatively low rates of self-reward and of high rates of self-punishment" (p. 794). This model lends itself to a more concrete therapeutic approach by characterizing the cognitive distortion process in behavioral terms.

A recent application of Rehm's self-control model to a therapeutic approach for adolescents was made by Reynolds and Coats (1986). Their five week training program focused on each of Rehm's (1977) self-control manifestations and provided training in skills to overcome specific deficits. Their results showed a significant reduction of depressive symptoms, based upon self-report and interview measures, compared to a wait-list control group. Interestingly, however, when they compared the self-control therapy results with those of another group receiving relaxation training therapy, neither therapy proved more effective than the other.

A third variation on the cognitive approach, called behavior problem-solving, was tested by Stark, Reynolds and Kaslow (1987) with a group of 9 to 12 year old children. The unique aspect of this approach was that, added to the features of self-control therapy, was the modeling of problem-solving skills and the development of "strategies for increasing the occurrence of pleasant activities and decreasing the occurrence of unpleasant activities" (p. 100). This approach also produced a significant reduction in depressive symptoms compared to a wait list control, but not compared to a group receiving only the self-control therapy, which produced an equally significant reduction.

Another approach to therapy is implied in the correlation between adolescent depression and lack of social skills, as measured on the Matson Evaluation of Social Skills with Youngsters. This finding suggests that social skills training might itself be effective as a treatment for depression. While there have been no reports of such an approach with depressed adolescents, Matson, Esveldt-Dawson, Andrasik, Ollendick, Petti, and Hersen (1980) adopted a social skills training approach with four emotionally disturbed children, ages 9 to 11, who were being treated on an in-patient basis at a residential treatment center. Two of these children were trained in appropriate use of three types of target verbal responses (e.g. giving compliments, giving help, and making appropriate requests). The other two only observed the training sessions. The two who received training showed significantly greater improvement in their social skills functioning, and reports from ward staff indicated that their interactions with other children had also significantly improved. However, the small sample size, the diffuse symptomatology of the subjects, and the lack of controlled pre- and post-treatment ward observations make this study of questionable value in assessing the effectiveness of social skills training as a treatment for depression in adolescents.

A study which was done on college students, whose ages ranged from 18 to 30, is worth mentioning here because it presents an unusually atheoretical therapeutic framework with unusually significant treatment effects. Reuter (1980) included in his sample 18 students who had scored in the moderately depressed range on the Beck Depression Inventory. Nine subjects were given a treatment of therapeutic counseling only, while the other nine were given therapeutic counseling plus "running therapy", which consisted of a regimen of jogging three times weekly for twenty minutes for a period of ten weeks. At the end of the ten weeks the latter group's average score on the BDI was lowered from 207 to 46, well within the normal range, while the former group's average score was lowered from 208 to only 167, still within the moderately depressed range.

In general, there have been few controlled studies on the effects particular therapeutic approaches to adolescent depression. Those reviewed here do not exhaust the list, but they are representative of the current literature. (It should be noted, however, that this review is purposely ignoring the rather extensive literature on the application of drug therapy to adolescent depression, a subject that goes beyond the scope of counseling psychology.) Most of the studies reviewed here suffer from one or more of the following limitations: small sample size, non-randomly chosen sample, and inadequate follow up on maintenance and generalization of learned behaviors. In addition, because there is so little agreement on the appropriate assessment of depression, there is an unusually wide range of symptoms and behaviors which may qualify as "depression", rendering the equivalence of the different samples of depressed adolescents highly suspect.

The two comparative studies reviewed (Reynolds & Coats, 1986; Stark et al, 1987) showed no significant differences between the therapies in terms of effectiveness in the reduction of depressive symptoms. This suggests the possibility of a "Hawthorne effect", or treatment effects not dependent upon the particular treatment approach but rather upon the added attention that any sort of treatment can afford to subjects. Such an effect may be especially visible with the depressed population, whose particular symptoms revolve around feelings of being unworthy of others' attention. This notion receives further support from Williams (1988), who studied the effects of a multi-factor treatment approach to adolescent depression. This treatment program, called the Coping with Depression Course -- Adolescent Version (Clarke & Lewinsohn, 1984), was a "14-session course designed to teach relaxation, cognitive, assertiveness, problem-solving, and communication skills and strategies for increasing pleasant events" (p. iv). Results revealed that the treated adolescents showed significant improvements over untreated controls in terms of reduced depressive symptoms. However, an interesting added finding was that the treated subjects "did not appear to improve in the skills that theoretically were designed to produce those changes" (p. 54). In other words, it appears that depression reduction was unrelated to the actual acquisition of particular skills, but was dependent on the belief by subjects that the motions they were going through would somehow relieve them of their depression.

Such findings do not necessarily suggest that the choice of therapeutic approach to adolescent depression is irrelevant. Certain approaches may be shown eventually to be superior to others. However, it will take a much greater number and sophistication of controlled studies than is presently to be found in the literature to make that case. Until then, educated hunches and therapy fads will likely continue to determine the decisions made about appropriate treatment of adolescent depression.

Other Related Factors

A few comments need to be made, in closing, about other factors that might be included in any analysis of adolescent depression. One of the most significant of these is the apparent "gender effect". For example, Allgood-Merton, Lewinsohn, and Hops (in press) studied the results of a battery of self-report measures of depression among several hundred high school students. Girls reported significantly higher levels of depression in all age groups. In addition, among the symptoms identified, girls, in comparison to boys, reported significantly lower self-esteem, significantly higher self-consciousness and anxiety, significantly greater concern over physical appearance, and a significantly higher incidence of stressful events in the recent past. This recent study is only a more thoroughly researched confirmation of earlier studies (e.g. Rierdan, Koff, & Stubbs, 1988; Peterson, Ebata, & Sarigiani, 1987) which also suggest that girls in late adolescence are more prone to depression than boys and exhibit a configuration of symptoms that is unique to them. This is not surprising given the stereotypic roles traditionally imposed upon men and women in our society. From a treatment perspective, these findings suggest that different therapeutic emphases might be employed depending upon the gender of the client.

Another factor to be noted about adolescent depression is that family and other social variables play a significant role. Stivers (1988) asked adolescents and their parents to take the Suicide Depression Inventory (Martin, 1974). He found a significant correlation between the profiles of the adolescent and mother, but none between the adolescent and father. Feldman, Rubenstein and Rubin (1988) found that, among the families of 103 sixth graders, over 50% of the variation in depressive affect among the students could be explained by variables representing family cohesion and friendship support; "adolescents from single parent families with low friendship support had scores in the clinically depressed range" (p. 275). Finally, Siegel and Griffin (1984) found that "parental divorce and socio-economic status were also found to be associated with higher levels of depression" among adolescents (p. 475). These findings lend support to the as-yet untested notion that individually oriented therapies may not be as effective as ones which attempt to focus upon the larger social matrix of the depressed adolescent.

Concluding Remarks

This brief overview of adolescent depression provides far more questions than answers; but this should not be surprising in a field such as counseling psychology, which, despite the growing number of experimental studies, remains primarily an art, rather than a science. The literature reveals a wide range of assessment and treatment approaches to adolescent depression. Assessment can be as brief as a 20 minute pencil and paper response to the Child Depression Inventory or as extensive as the several hour long Kiddie-SADS interview. Treatments range from the elaborately theoretical and intellectually oriented cognitive therapies to the relatively atheoretical, action oriented "running therapy". Almost all treatments report significant reduction in depressive symptoms as compared to untreated controls. Yet the two comparison studies cited above reported no significant differential effects among the treatments compared. Furthermore, one study found that a particular treatment, involving the learning of a set of coping skills, was effective in reducing depression even though the coping skills were not actually learned. These findings suggest that the effect of some therapy, as opposed to none, is so great that it reduces to insignificance the more subtle effects, if any, that might be associated a particular approach.

Finally, it was noted that certain related findings regarding depression in adolescents may influence future directions in treatment. First there appears to be a gender effect, in terms both of prevalence and symptoms, on depression in older adolescents. This may suggest a differential theoretical analysis, perhaps more closely tied to social learning theory, in which socially determined gender roles are taken into account. This, in turn, may generate a more complex, gender sensitive treatment approach. Second there appears to be a strong family and social network influence on the appearance and intensity of adolescent depression. Greater attention needs to be paid in the future to such factors as family cohesion, friendship support and other social forces in both the theoretical and the therapeutic approaches to adolescent depression.

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APPENDIX: TABLES

TABLE A-1

Condensed versions of the Weinberg and Feighner symptoms for childhood depression

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Major Symptoms and Behavioral Components

- I. Dysphoric Mood (Melancholy)
  - a. Statements or appearance of sadness, loneliness, unhappiness, hopelessness, and/or pessimism
  - b. Mood swings, moodiness
  - c. Irritable, easily annoyed
  - d. Hypersensitive, cries easily
  - e. Negative, difficult to please
- II. Self-deprecatory Ideation
  - a. Feeling of being worthless useless, dumb, stupid, ugly, guilty (negative self-concept)
  - b. Beliefs of persecution
  - c. Death wishes
  - d. Desire to run away or leave home
  - e. Suicidal thoughts
  - f. Suicidal attempts
- III. Aggressive Behavior (Agitation)
  - a. Difficult to get along with
  - b. Quarrelsome
  - c. Disrespectful of authority
  - d. Belligerent, hostile, agitated
  - e. Excessive fighting or sudden anger
- IV. Sleep Disturbance
  - a. Initial insomnia
  - b. Restless sleep
  - c. Terminal insomnia
  - d. Difficulty waking in morning
- V. Change in School Performance
  - a. Frequent complaints from teachers re: daydreaming, poor concentration, poor memory
  - b. Loss of usual work effort in school subject
  - c. Loss of usual interest in nonacademic school activities
- VI. Diminished Socialization
  - a. Decreased group participation
  - b. Less friendly, less outgoing
  - c. Socially withdrawing
  - d. Loss of usual social interests
- VII. Change in Attitude Toward School
  - a. Does not enjoy school activities
  - b. Does not want or refuses to attend school
- VIII. Somatic Complaints
  - a. Nonmigraine headaches
  - b. Abdominal pain
  - c. Muscle aches or pains
  - d. Other somatic concerns or complaints
- XI. Loss of Usual Energy
  - a. Loss of usual personal interests or pursuits other than school: e.g., hobbies
  - b. Decreased energy: mental and/or physical fatigue
- X. Usual Change in Appetite and/or Weight
  - a. Anorexia or polyphagia
  - b. Unusual weight change in past four months

Taken from Matson (1989).

TABLE A-2

Depression in children

Item numbers, item names and factor loadings for the 27 items of the CDI[a]

Item number	Item name[b]	Factor loadings
Factor 1: Affective Behavior		
2	Nothing will ever work out for him/her	(0.35)
3	(S)he does everything wrong	(0.36)
10	(S)he feels like crying everyday	(0.42)
11	Thing bother him/her all the time	(0.49)
13	(S)he cannot make up his/her mind about things	(0.49)
15	(S)he has to push him/herself all the time to do school work	(0.50)
16	(S)he has trouble sleeping every night	(0.35)
17	(S)he is tired all the time	(0.41)
18	Most days (s)he does not feel like eating	(0.35)
23	(S)he does very very badly in subjects (s)he used to do good in	(0.45)
Factor 2: Image/Ideation		
1	(S)he is sad all the time	(0.55)
6	(S)he is sure that terrible thing will happen to him/her	(0.42)
7	(S)he hates him/herself	(0.65)
9	(S)he wants to kill him/herself	(0.32)
14	(S)he look ugly	(0.42)
19	(S)he worries about aches and pains all the time	(0.28)
Factor 3: Interpersonal Relations		
4	Nothing is fun at all	(0.65)
12	(S)he does not want to be with people at all	(0.56)
20	(S)he feels alone all the time	(0.48)
21	(S)he never has fun at school	(0.47)
22	(S)he does not have any friends	(0.51)
24	(S)he can never be as good as the other kids	(0.51)
25	Nobody really loves him/her	(0.32)
Factor 4: Guilt/Irritability		
5	(S)he is bad all the time	(0.59)
8	All bad things are his/her fault	(0.65)
26	(S)he never does what (s)he is told	(0.52)
27	(S)he gets into fights all the time	(0.59)

[a] Item names are an approximation of the item content. Each item can be rated in one of three ways with 0 being a desirable response, 1 being a moderately-acceptable response and 2 being an undesirable response. An example of this response mode is exemplified by Item 1 which reads as follows: (0) (S)he is sad once in a while; (1) (S)he is sad many times; (2) (S)he is sad all the time.

[b] Undesirable statements of each item are presented (see scale description).

Taken from Helsel and Matson (1984).

TABLE A-3

The Hopelessness Scale for Children: Items and Item–Total Score Correlations

Item	Item–total *r*
1. I want to grow up because I think things will be better (F).	.36**
2. I might as well give up because I can't make things better for myself (T).	.45**
3. When things are going badly, I know they won't be bad all of the time (F).	.43**
4. I can imagine what my life will be when I'm grown up (F).	.10*
5. I have enough time to finish the things I really want to do (F).	.44**
6. Someday, I will be good at doing the things I really care about (F).	.37**
7. I will get more of the good things in life than most other kids (F).	.22**
8. I don't have good luck, and there's no reason to think I will when I grow up (T).	.51**
9. All I can see ahead of me are bad things, not good things (T).	.58**
10. I don't think I will get what I really want (T).	.48**
11. When I grow up, I think I will be happier than I am now (F).	.40**
12. Things just won't work out the way I want them to (T).	.48**
13. I never get what I want, so it's dumb to want anything (T).	.50**
14. I don't think I will have any real fun when I grow up (T).	.54**
15. Tomorrow seems unclear and confusing to me (T).	.41**
16. I will have more good times than bad times (F).	.47**
17. There's no use in really trying to get something I want because I probably won't get it (T).	.56**

Note. An item is scored as reflecting hopelessness if the answer is true (T) or false (F), as noted at the end of each item.

* $p < .05$. ** $p < .001$.

Taken from Kazdin, Rodgers, and Colbus (1986).

COUNSELING THE BEREAVED CHILD:
A School Counselor's Perspective

by

David Boyle
Oregon State University
Department of Counseling

It is unlikely that a school counselor would positively look forward to counseling bereaved students, yet according to two authors ,it can be an extremely rewarding part of the job (Getson & Benshoff, 1977). The grieving child needs to learn to live with death, accept it and go on with life (Smith, 1989). It is a great challenge to help another with this grieving process. Counselors often ignore or slight the significance of this challenge.

It has been reported in several studies there is an increased likelihood of psychopathology later in life for those individuals who have lost a parent during early life stages (Jones; Getson & Benshoff; Gray, 1988). This paper's author has found no studies that purport proven ways of lowering the likelihood of psychopathology but many articles suggest ways that this might take place. The purpose of this paper is to compile and summarize these suggestions and to discuss the effects of the death of a loved one on a child of school age.

THE CHILD'S REACTION TO DEATH

The child's reaction to death will depend on their stage of psychosocial development. Three distinct developmental phases occur during the school career

(Isaacs & Taylor, 1989). The first phase occurs between the ages of 6 - 9. The child begins to see death as final but lacks an understanding of death. There is an interest in the details of death and many questions about the events leading up to death. Children often personify death (Jones) in a magical or even violent way. Some children think that the dead can see or hear the living. "Such thoughts may lead to internalization of excessively high standards because the child is trying to be perfect for the deceased" (Bertoia & Allan, 1988). The child's language is not sophisticated and confusion about wording can easily arise. Saying that someone has "gone to sleep" can lead to the child attributing death to sleeping. It would then be logical to fear going to sleep (Isaacs & Taylor, 1989).

According to Isaacs and Taylor, (1989) the next phase occurs between ages 9 and 12. The child has gained a biological understanding of death and may begin to have an interest in the spiritual aspects of death. Morality has developed with a defined sense of good and bad. This may lead to thinking that death is a punishment for bad behavior. The child may need to be reassured that wishes do not kill. Along with this increased understanding is a concern for the loss of relationships caused by death and concern for who will provide care for them.

The final school age stage comes in the teens. Teenagers view death as inevitable and irreversible but see themselves as invincible. Death occurs to others. A teenager may question the meaning of life if it ends in death. The teenager may feel guilt, anger, and even some responsibility for causing the death (Issacs & Taylor, 1989). There is need for adult guidance and modeling of ways to deal with these feelings.

Regardless of the stage that the child is in, the death of a loved one forces the child to deal with death when that child's concept of death is weak. Older children may even begin to explore the possibility of their own personal death (Jones, 1977).

Similarly, the reaction to the death of a loved one is also profound and varied. This variety of reaction is summarized in *Helping Children Cope With Loss* (Isaacs & Taylor, 1989). Issacs and Taylor (1989) and Ryerson (1977) state that children often feel guilt arising from a feeling of responsibility for the death. This guilt manifests itself in children making statements like "If only I had", or "I told her I wished she would die". If there has been a long illness before the death, the child may feel a sense of relief and may find it difficult to admit to this relief. There may be an emotional explosion from anger at the person who has died, at God for letting this happen, or at the medical profession for not doing enough. The child may feel panic and fear and wonder who will take care of them (Ryerson, 1977). Sadness, emptiness, and loneliness are often results of death experiences.

All of the above reactions can be accompanied by physiological responses like tiredness, lethargy, headaches, and lack of appetite. The child may act out, withdraw, or exhibit behaviors deemed inappropriate by society. Finally, the child may come to think of the possibility of personal death. This can result in fear, confusion, and grief for the bereaved's self. (Getson & Benshoff, 1977).

THE COUNSELORS' RESPONSE

For this paper, my comments are limited to responding to children after they have been told of the death of a loved one. There seem to be three main categories of interventions that are useful with grieving students at school (Jones, 1977). These are: individual counselor intervention; support in the classroom from the teacher and friends; and bereavement groups. "The goal (of all interventions) is to create a safe, caring environment in which the adolescent can begin to unravel his or her death-related concerns" (Calvin & Smith, 1986 p 218-219). The above interventions are not necessarily exclusive of each other but they will be presented separately in this paper.

COUNSELOR INTERVENTIONS

Although grief counseling is demanding and emotionally draining, it is work within the realm of the well trained school counselor (Jones, 1977). The primary difficulty to the counselor is the reminder of death in the private life of that counselor (Getson & Benshoff, 1977; Isaacs & Taylor, 1989). The counselor must be comfortable in dealing with the topic of death (Jones, 1977). If not, this discomfort may be interpreted by the bereaved student as avoidance. Thus the student might try to deal with grief alone, by internalizing it. This could lead to difficulties later because of unfinished grieving (Bertoia & Allan, 1988; Isaacs & Taylor, 1989).

The counselor may need to seek the person who is grieving. Teenagers in particular may be reluctant to talk or may feel embarrassed that they are now viewed as different. One must be careful not to bring too much attention to bear on grieving students since many are already feeling alienated (Gray, 1988). School mates tend to withdraw from the grieving student because they think they do not know what to say. This withdrawal could lead to internalization of grief as mentioned previously. Counselors also feel "an unreasonable but real need to say the right thing" (Getson & Benshoff,1977). Getson and Benshoff suggest that it is important to acknowledge the child's grief simply, and to indicate to the student a willingness to talk.

After opening a line of communication, there are many possible choices of direction for counseling. Many researchers state that listening to the student's viewpoint is critical. Through this, the counselor can gain an awareness of the child's understanding of death. In coordination with the students' family, the counselor may even find it necessary to help the student to form a more functional concept of death (Jones, 1977).

Another critical element of the counseling process with grieving students is to communicate that it is safe to express fear, anxiety, and guilt. It is possible that the child feels responsible for the death because of some unfortunate remark. There must be encouragement to express reassurance that the child was not responsible for the death (Ryerson, 1977). Yet, the counselor must also be patient with this process (Isaacs & Taylor, 1989). The child may have done or felt something that was deemed socially unacceptable and so may feel guilty. A 15 year old client of the author's began to laugh during the funeral of her grandmother. She left the service immediately to deal with these emotions privately but was chastised for having "inappropriate emotions". She thought there was something wrong with her and felt guilty for laughing. After discussion, she decided that laughing was her usual reaction to stress. She then could see that her actions were not appropriate culturally, but were quite natural.

Words or touch should be used to demonstrate how much the counselor cares (Isaacs & Taylor, 1989). "Touching when touching is needed may contribute so much that it outweighs the very slight possibility that it will not be desired" (Getson & Benshoff, 1977, pg 313). There needs to be a caution added to this, however. The counselor must be careful not to use touch as a technique but should only touch to express a feeling of closeness that is more than verbal expression.

Later counseling sessions should move toward helping the child with acceptance of the reality of death (Jones, 1977). This can be done by gently encouraging the child to remember various aspects of their relationship with the deceased. It is important that both positive and negative memories be discussed. Anger and hostility toward the deceased can be discussed and released. At the same time positive memories can be recalled and celebrated (Ryerson, 1977).

Calvin and Smith (1986) have hypothesized that the bereaved person's sense of loss is directly proportional to the number, extent, and exclusivity of functions that the deceased provided for the survivor. These functions were originally pointed out in Putney's (1981) article on the basic functions of interpersonal relationships in support systems. These functions are: intimacy, guidance and assisting, competency, companionship, nurturing, maintenance, and security. If a counselor can help the bereaved clarify functional losses then that person can acknowledge the significance of the deceased and begin to recover those lost functions in other ways.

Children tend to grieve in their own way, in their own time. The child's friends who are not grieving may eventually be distanced from the child who is still grieving (Jones, 1977). This distancing can lead to internalization of grief unless support can be given in other ways. One possible answer is bereavement groups made up of students who have experienced loss. These groups shall be discussed later.

The counselor needs to be aware of more severe reactions to loss. These reactions might include failure to demonstrate any grief, continuing belief that the deceased will return, medical problems, extreme anger and acting out (Jones, 1977; Isaacs & Taylor, 1989). Such reactions may require referral or different tactics than mentioned above.

THE FRIENDSHIP NETWORK

"Bereaved teenagers...most often reported (40%) that the 'most helpful person' in dealing with their loss was a peer" (Gray, 1988). Close friends of the student can be called together to discuss how their friend is feeling. Ways that the friends can be helpful to their grieving friend can be discussed with the counselor (Jones, 1977; Gray, 1988). It would be useful to point out that the friend greiving may need support for a long time and that the grieving process is different for everyone. There are many resources available for this discussion (see Appendices A & B).

This author considers the bereaved student's classroom as a potential friendship network. If properly prepared, classmates can ease the bereaved student's return to school. It may be useful merely to allow the students in the class to discuss their own concerns about death and to explore what they could say to their grieving classmate. This would allow the grieving student to return to a classroom where the death is no longer a taboo subject (Jones, 1977;

Bertoia & Allan, 1988). Often the bereaved student faces concerns of how to act and what to say (Nelson, 1977). If counselors prepare students to be supportive, the return of the bereaved friend to school could be a safer venture.

Another potential set of supportive people in the school are the teaching staff. They need to be prepared to be helpful to the bereaved student as well. Gray (1988) studied ways in which various social supports were helpful or not helpful in dealing with the student's loss. Teachers were often reported to be unhelpful or helpful only in minimal ways (Gray, 1988). Those teachers that were unhelpful told students to focus on school instead of grief. Those that were helpful made allowances for the child's situation but did not draw unnecessary attention to them (Nelson, 1977).

Teachers need to be made aware that grieving children are often not able to articulate their feelings and may act out instead. Some ways of acting out may even be healthy expressions of grief. For example, emotional explosions could be useful releases of anger and should be accepted as such and worked through (Isaacs & Taylor, 1989).

It is risky to tell teachers exactly what is needed because so much of what needs to be done is defined by the situation. Asking that teachers state a willingness to listen to the student may be useful. It would also be appropriate to request that the teacher gently refer the student to counseling when the teacher feels uncomfortable.

BEREAVEMENT GROUPS

Another strategy that has been used by many counselors is support group counseling. Bereaved students are invited to attend sessions with other students who have experienced loss. This is effective for many reasons. As was mentioned earlier, grieving can be a long process. A support group of others going through the same process provides an outlet for grief work. Thus, the grieving student could return to "normal" in the presence of friends and concurrently would not feel isolated to grieve alone. Also, grieving students could learn from and care for others in the same situation (Nelson, 1977).

WORKING WITH FAMILIES

Counseling that is done at school cannot operate in isolation from events occurring at home. The bereaved student usually has to deal with others in the home who are also grieving. This interaction can lead to frustration and a sense of loneliness if others in the home have not shared their grief (Jones, 1977). In talking with the counselor and others grieving students, bereaved students can facilitate communication with those at home. Through talking with the counselor, the student is practicing communication that may need to occur at home. With practice at school, it is easier to start this communication at home (Gray, 1988).

Bereavement is a problem that spans the school and the home. The counselor can facilitate this communication directly by arranging parent-child conferences. Care, however, must be taken to protect the trust built with the student.

PERSONAL REACTION AND CONCLUSION

The studies that were reviewed for this paper contained many different techniques. Some authors based their techniques on a developmental theory which was outlined in the body of the paper (Bertoia & Allan, 1988; Jones, 1977; Isaacs & Taylor, 1989: Nelson, 1977). Many discussed grieving as a process of accepting the reality of death (Jones, 1977; Getson & Benshoff, 1977; Ryerson, 1977; Isaac & Taylor, 1989). This process was mentioned by Yalom and May (1989, p. 376) as one of the four inner conflicts of the existential frame of reference. All of the individual techniques involved establishing empathy, unconditional positive regard, and a good counselor - counselee relationship. This author classifies these techniques as primarily client-centered, although not exclusively so. The group techniques mentioned appear to be those of an existential therapy group, although students prefer to consider their groups as support groups (Gray, 1988). The groups focus on the "here and now" and structure their agenda's from situations rather than any patterned agenda.

It appears to this author that counselors using family systems theory could serve to better coordinate the grieving process for students. The bereaved student has lost part of the family system. This loss leaves a gap in the normal pattern of relationships. The bereaved person tries to find new order in the family system while grieving for the missing part. That same bereaved person is a member of many subsystems of individuals at school. The individual is a member of a system of close friends, classmates, school, and students going to see the counselor. Sometimes the bereaved student may feel cut off from any system - an isolate. A change in the pattern of relationships at home causes ripples to upset relationships everywhere within the systems that the individual touches. A counselor who is aware of the whole pattern can view the job ahead as helping the bereaved student to re-balance relationships within all external and internal systems. This author believes that changing the theoretical view to a more systems base would allow better coordination in supporting the bereaved student.

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ADOLESCENTS OF DIVORCE:
An Overview for School Counselors

by

Jean Coldsmith
Oregon State University
Department of Counseling

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Abstract

Adolescents of divorced parents can be helped by the school counselor. The developmental aspects of adolescence and the effects of divorce on adolescents are discussed. Based on a review of the current literature, group counseling is presented as the most common and effective method for the school counselor.

The high rate of divorce in America correlates to a high percentage of students in school whose parents have divorced. Omizo and Omizo, (1988) found some schools had as high as 80% of the students coming from broken homes. Research indicates the school counselor is in an excellent position to work with these teenagers, and that group counseling is the natural forum for conducting this work (Anderson, Kinney, & Gerler, 1984; Corey & Corey, 1987; Kalter, Pickar, & Lesowitz, 1984; Larabee & Terres, 1984: Omizo & Omizo, 1988; Sheridan, Baker & Lissovory, 1984).

An understanding of adolescence, the effects of divorce on adolescents, a rationale for using group techniques in schools, and examples and suggestions for a group format are presented.

Adolescents; a brief developmental overview.

Adolescence is a time of change; biologically, cognitively and socially. The beginning of adolescence is typically marked by the onset of puberty. The end of adolescence is not as clear, with the range being anywhere form 17 to 35 years of age. (Santrock, 1984). For the purposes of this paper all high school students will be considered adolescents.

Biologically the teen experiences the growth and physical changes of puberty. Reproductive organs mature, and hormonal changes occur. These new physical developments coupled with societal and peer expectations often create confusion, disequilibrium, and exploration for adolescents.

Piaget's developmental stages provides the framework for most psychologists to view the cognitive development of adolescents (Santrock, 1984). Piaget (1968) sees adolescents as entering into the "formal operations" stage. This stage is characterized by the teen being able to "draw conclusions from pure hypotheses and not merely from actual observations" (Piaget, 1968, p. 63). Adolescents therefore start thinking about possibilities, for themselves and for the world. These possibilities often take on idealistic proportions, where the adolescent believes they are strong enough and right enough to make these possibilities happen. True love exists, according to adolescents, but adolescents may not believe pregnancy could ever happen to them. Building on Piaget's theories, Kohlberg sees adolescents as able to move into a post-conventional moral stage (Santrock, 1984), where morals are based on an individual's own principles, not societal laws.

Another major theorist, Erikson, believes adolescence is a time of "identity crises," where the youth explores who they are and how they relate to others (Lipsitz, as cited by Coffman and Roark, 1988). "In part, this identity is established through an identification with the parents, especially the one of the same sex (Sorosky, 1977, p. 129). Because adolescents are, for perhaps the first time, developing who they are with their own plans and moral rights and wrongs, they are continually testing limits (Corey & Corey, 1987).

From a psychodynamic perspective the typical adolescent is experiencing the internal conflicts of self acceptance and expression, and the control of sexual and aggressive drives. Externally they are dealing with dependency and independence issues as well as social approval (Sorosky, 1977).

How adolescents react to the physical and cognitive changes is effected by their "...experience in their families, with their peers, and in the schools" (Santrock, 1984). Santrock cites Brittain, (1963) and Larsen, (1975) in stating that the family is the strongest influence on adolescents. Parenting style, the degree of conflict in the home, and how the conflicts are resolved all influence the development of an adolescent (Block, 1972, 1973: Haan et al., 1968 as cited in Santrock, 1984).

Adolescents' peer groups also influence their development. Santrock (1984) cites the following benefits to peer groups: 1) a place for developing social skill; 2) a buffer against feelings of aloneness; 3) a place for exploring their identity; and 4) an "anchorage" while moving towards independence. Peer groups however, can also exert a pressure to conform, which can lead to an overly dependent identification with their peer group.

Schools provide the framework for meeting friends and interacting with peers. Schools are also one way the adolescents learn about governments and societal expectations and norms. Adolescents are, as discussed earlier, questioning these societal standards and are beginning to develop their own standards.

Effects of divorce on adolescents.

The effects divorce has on adolescents depend on many factors. Arthur Sorosky (1977) lists the following:

> a) the psychodynamics of the family prior to the divorce, including the severity of marital discord; b) the nature of the marital breakup; c) the post-divorce relationship of the parents; d) the age or stage of development of the youngster at the time of the divorce and e) the personality, strengths and coping skills of the adolescent (p. 123).

Herlihy (1984) and Wallerstein (1983) also support the influence of these factors. Wallerstein (1983) goes on to state that "...mastery or failure as outcomes require separate scrutiny and understanding of a child and of the child's effort on his or her own behalf" (p. 232). The fact that each teenager will react to divorce in different ways should be noted. However, despite these differences there are some common effects and reactions to divorce that can be anticipated when working with adolescents whose parents have divorced. They are:

1) Anger (Herlihy, 1984; Kelly & Wallerstein, 1977; Wallerstein, 1983; Young, 1980).

2) Anxiety (Irion, Coon, & Blanchard - Fields, 1987; Kalter, Pickar, & Lesowitz, 1984; Wallerstein and Bundy, 1984).

3) Disruption of developmental process (Kalter et al. 1984; Kelly & Wallerstein, 1977; Sorosky, 1977).

4) Guilt, self - blame for the divorce (Herlihy, 1984; Omizo & Omizo,1987; Sorosky, 1977; Young, 1980).

5) Feelings of powerlessness, loss of control (Herlihy, 1984; Irion, Coon & Blanchard-Fields, 1988; as cited in Omizo et. al.1987; Wallerstein 1983; Young, 1980).

6) Behavioral difficulties, especially boys (Hammond, 1979; Guidubaldi, Cleminshaw, Perry & Mcloughlin, 1983)

7) Sadness over loss of noncostodial parent, family unit (Kalter et al. 1984; Wallerstein, 1983; Young, 1980).

8) Feeling abandoned (Omizo, 1987; Sorosky, 1977; Young, 1980).

9) Negative self concept (Omizo, 1987; Parish & Wigle, 1985). *Hammond (1979) found no difference in self concept in children of divorced parents vs. intact families.

10) Conflicted loyalties (Kalter, Pickar, & Lesowitz, 1984; Kelly and Wallerstein, 1977; Wallerstein & Bundy, 1984; Young, 1980).

11) Concerns over parents dating (Kalter et al. 1984)

12) Less mature coping strategies (Irion et al. 1988)

13) Not surprised, sense of relief (Sorosky, 1977).

14) Overburdened (Sorosky, 1977; Wallerstein, 1983)

15) Sexually promiscuous (Hammond, 1979; Sorosky, 1977; Wallerstein, 1983).

Based on Erikson's work, the bereavement stages and Wallerstein's own research, Wallerstein (1983) has identified 6 tasks children and adolescents of divorce face. These tasks are:

"...shaped by the threats or perceived threats to psychic integrity and development which the divorce process poses to the

> child. The are conceptualized as hierarchical, as following a particular time sequence beginning with the critical events of parental separation and culminating at late adolescence and young adulthood (p. 231).

A brief description of the tasks follow:

Task I: Acknowledging the Reality of the Marital Rupture. This task is marked by extreme anxiety and is typically resolved through the acknowledgment of the previlence of divorce in American society. Mastery of this task usually occurs with-in 1 to 1-1/2 years (pp. 234 - 235).

Task II: Disengaging from the Parental Conflict and Distress and Returning to Costumary Pursuits. It appears difficult for adolescents to master this task and maintain their pre-divorce level of activity. Resolution usually comes with-in 1 to 1-1/2 years (pp. 236 - 237).

Task III: Resolution of Loss. At the base of this task is overcoming the sense of rejection and powerlessness that divorce brings on. It often takes several years for the adolescent to resolve the loss (pp. 237 - 238).

Task IV: Resolving Anger and Self Blame. Adolescents know that divorce is the choice of at least one parent. That knowledge brings feelings of blame, either to a/the parent(s) or to themselves. Resolution of the anger comes from a realistic understanding for the reasons of the divorce and a better understanding of the parents (pp. 238 - 239).

Task V: Accepting the Permanence of the Divorce. This task is not as critical to the adolescent as it is to the child, as the adolescent has a better understanding of the permanent nature of divorce (pp. 239 - 240).

Task VI: Achieving Realistic Hope Regarding Relationships. This task typically will not be resolved before the adolescent years, adding to the normally turbulent teen years.

> "For in order to trust in the reliability of relationships and maintain the capacity to love and be loved, the child of divorce will need to have acquired confidence in his or her lovability and self worth" (p. 242).

Wallerstein sees this task as the most crucial for the child and society (pp. 240 - 242).

These tasks tie together the development of children with the effects of divorce, and provide a general framework for counselors to view the adolescent of divorced parents.

Rationale for Using Groups

The vaste majority of the literature offers group counseling for working with children of divorce in the school setting. While a few mentioned individual counseling as an option or a supplement to groups, a discussion of the advantages of individual counseling over group counseling in the schools was not found. Several articles did, however, give a rationale for using group techniques. This position is well stated by Kalter, Pickar, and Lesowitz (1984) :

> The public school increasingly has been regarded as a natural setting for such interventions. First, schools offer an excellent opportunity to reach and engage a substantial percentage of children of divorce. Second, there is a ready made peer structure present which can serve to mediate the intervention. Finally, locating the intervention in the familiar context of school can begin the process of normalizing the divorce experience (p. 614).

Groups also provide opportunities for adolescents to know they are not alone in what they are experiencing, and can give them a safe environment to test limits and realities (Corey & Corey, 1987).

In the five schools singled out by the American School Counselor Association for their excellent programs, all kept individual counseling to a minimum, and made conscious efforts to use groups (Larabee & Terres, 1984). Sheridan, Baker and Lissovory (1984) speculate that groups are "...more likely to prevent future problems than is traditional, as needed, individual counseling " (p. 140). Students also showed improved attitudes and behavior after participating in a divorce support group (Omizo & Omizo, 1988; Anderson, Kinney, & Gerler, 1984).

Perhaps the reason for such a lopsided presentation of group work is due to the nature of school counseling. The high student - counselor ratio makes it very difficult to engage in long term, individual counseling with the numbers of students effected by divorce. Group counseling enables the counselor to reach many more students, as well as providing the benefits mentioned above. More information concerning the benefits and techniques of individual counseling of children of divorce may be beneficial, as students needing more attention can sometimes be served by either the school counselor, or through referral.

Group Goals and Techniques

Before forming divorce groups each teenager should be assessed individually to determine [illegible] he or she is effected by the divorce and to make sure his or her needs are being met. Identification of students from divorced families can be made through student records, teacher and parent referrals, self referrals, and through the counselor's own observations. It is important to note that not all students of divorce will need counseling (Strangeland, Pellegreno, and Lundholm, 1989; Wallerstein and Bundy, 1984).

The literature reveals many group formats for children but very few specifically for adolescents. As pointed out earlier, the already difficult developmental tasks adolescents face are compounded by the divorce. More study into the effects and methods of counseling that will address these specific needs of adolescents is necessary.

An overview of the three articles found on school groups for adolescents of divorce follows. After each group example this author gives a brief reaction to the format and techniques.

Example Group 1

Coffman and Roark (1988)

Goals: Based on Wallerstein's (1983) previously cited six tasks.

Identifying/ Assessment: The counselor met with each 10th grade English class, presented for 5 minutes on small group process and the needs of adolescents of divorce. Students filled out a questionnaire stating interest in the group. No screening was indicated.

Logistics 5 - 10 students

5 - 6 sessions (length of sessions not given)

Session 1: a)overview of rules

b)information about the effects of divorce given

c) counselor reflects and clarifies, focusing on effects and "I" and "WE" interactions. (see Table 1)

Session 2 - 5: a)counselor focuses on "we" interactions

b)group runs itself in terms of direction of discussions

Reaction: This group format is student-centered, where other that the 1st session, the direction the group takes is primarily left to them. The counselors role is one of facilitator, using the basic Rogerian skills.

Example Group 2

Coffman (1988)

Goals: Adolescents with divorced parents will be better able to handle interpersonal conflicts and see conflict as an opportunity for growth, when they have mastered a conflict - resolution strategy.

Identifying / assessment Not discussed

Logistics: 5 - 10 students

4 - 50 minute sessions

Session 1: Students identify areas of conflict and their own resolution methods. Each student should is expected to accurately express what the person before him or her has said, before stating their own issues.

Session 2 - 4: The goal of these sessions is to learn a 5 step conflict resolution process.

Step 1: a cognitive description/ understanding of the conflict

Step 2: describe feelings of conflict, without statements of blame.

Step 3: 'Conflictees' should be able to: a) agree on perceptions of conflict; b) understand each others feeling; c) agree on a situation that would reduce conflict.

Step 4: Each person makes a list of changes necessary to create the situation described in 3(c).

Step 5: An agenda to implement the changes should be made.

Reaction: It seems a simple and helpful model for conflict resolution. Primarily it appears to be a directed group, that emphasizes learning Rogerian communication skills. Being able to see the others point of view is beneficial. The student may become frustrated when the other conflictee outside of the group has not learned this model. Perhaps more information on the effects of divorce on adolescents would be beneficial.

Group 3

Omizo and Omizo (1988)

Goals: To clarify and to share the teen's feelings about divorce; understand that others have similar feelings, to gain a realistic view of the situation; to learn coping strategies, to gain support for each other.

Identification/assessment: Not given, although students did volunteer and parents signed permission slips.

Logistics: group size - 10
10 sessions, 45 min. to 1 hour long

Session 1: Introduction and rules (use of "breaking the ice" type of activities)

Session 2: Nondivorce - related self disclosure (use of structured activities)

Session 3: Bibliograhy on divorce and discussion

Session 4: Divorce-related self disclosure

Session 5: Brainstorm, then role play the problems of divorce

Session 6: Continued role playing - followed by in-depth discussion

Session 7: Positive aspects of divorce (make a collage to express these aspects)

Session 8: Building Self Esteem: participants describe themselves, with positive feedback from the group

Session 9: Coping with parents' divorce - stress management techniques, communication skills and empathy introduced

Session 10: Wrap - up. Summarize, feelings expressed, and feedback

Reaction: A directed group experience with activities that focus on a combination of learning about divorce and coping skills, and of identifying and expressing feelings. The last four sessions were focused on positive aspects of divorce and coping with divorce.

These are just three formats presented for working with adolescents of divorced families. They are dissimilar in that the first focuses on affect, the second primarily on a conflict resolution, and the third combines the affect with coping strategies. While different, they all seem to have a common core in that the therapist uses a humanistic approach, emphasizing communication skills, and understanding one's own as well as others' feelings. This common factor was also found in the literature for children's support groups. Group work for adolescents in the schools seems to be the trend, for the therapeutic benefits of group, as well as the time and number constraints faced by the school counselor.

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COUNSELING CHILDREN WITH AN OVERANXIOUS DISORDER

by

Karla Kerstner
Oregon State University
Department of Counseling

Counseling Children With An Overanxious Disorder

Introduction

Psychologically healthy persons are neither dominated by fear nor oblivious to it. What characterizes healthy personalities is the ability to recognize and regulate anxiety. Like pain, fear is unpleasant. But, like pain, it has the equilibrating function of keeping persons alert to danger. It is the inability to cope with anxiety rather than anxiety itself that is deleterious (Giordano, 1987).

The objectives of the present paper are the following: (a) to briefly discuss the current literature on Overanxious Disorders; (b) to discuss the diagnostic criteria for Overanxious Disorder, as described in the DSM-III-R; (c) to discuss assessment methods for an Overanxious Disorder; and (d) to look at treatment modalities used with children diagnosed with an Overanxious Disorder.

Current Literature

Unlike the flurry of activity that has characterized the area of adult anxiety, relatively little work has been conducted on anxiety disorders in children (Silverman, 1987; Strauss, 1988; Francis, 1988; Last, Strauss, & Francis, 1987). This lack of research on anxiety disorders in children is unfortunate, because there is a relationship between child and adult anxiety. There appears to be a significantly greater chance of children with OAD developing a general anxiety disorder as adults than children without OAD (Raskin, Peeke, Dickman & Pinsker, 1982; Last et al., 1987; DSM-III-R; American Psychiatric Association, 1987). Thus, further understanding about commonly occuring clinical anxiety in children may shed some light on anxiety in adults.

Despite the lack of information available on anxiety in children, a subcategory of childhood anxiety syndromes, called "Anxiety Disorders of Children and Adolescents", is included in the DSM-III-R. Overanxious Disorder is included in this subcategory.

Diagnostic Criteria For Overanxious Disorder

The essential feature of the Overanxious Disorder (OAD), is excessive worrying and fearful behavior that is not focused on a specific situation or object (such as separation from a parent or entering new social interactions), and that is not due to a recent psychosocial stressor (DSM-III-R; American Psychiatric

Association, 1987). To meet the DSM-III-R criteria for GAD, excessive or unrealistic anxiety or worry must persist for a period of six months or longer, as indicated by the frequent occurrence of a least four of the following:

(1) excessive or unrealistic worry about future events;

(2) excessive or unrealistic concern about the appropriateness of past behavior;

(3) excessive or unrealistic concern about competence in one or more areas, e.g. athletic, academic, social;

(4) somatic complaints, such as headaches or stomachaches, from which no physical basis can be established;

(5) marked self-consciousness;

(6) excessive need for reassurance about a variety of concerns;

(7) marked feeling of tension or inability to relax

(DSM-III-R; American Psychiatric Association, 1987, p. 64).

Demographic Characteristics

Studies have suggested that anxious symptoms are common in both male and female children of all ages (Abe & Masui, 1981; Oruaschel & Weissman, 1986). Investigations have not yet appeared that study the occurrence of DSM-III-R anxiety disorders in childhood and adolescence in the general population. However, data is available regarding the demographic characteristics of overanxious disorder in one clinical sample (Last, Hersen, Kazdin, Finkelstein, & Strauss, 1987).

Age

Age is not a factor addressed in the DSM-III-R. However, the Last et al. (1987) study found the mean age of children with OAD at intake to be 10.8 years old.

Sex

According to the DSM-III-R, OAD is equally common in males and females. The Last et al. (1987) study concluded that more males than females were found to suffer with OAD.

Predisposing Factors

This disorder appears to be most prominent in families in which there is unusual concern about performance, high level of achievement, and a premium on conforming behavior (DSM-III-R; American Psychiatric Association, 1987; Compton, 1982; Last et al. 1987). Children in such families come to believe that they must earn acceptance by their acts. They frequently present themselves as overachievers, placing high expectations upon themselves to be competent (Silverman, 1987). Such conditions occur most frequently in small families, upwardly mobile families, and in first or only children (DSM-III-R; American Psychiatric Association, 1987; Compton, 1982). Strauss, (1988) found that almost all youngsters with OAD were from Caucasian families.

Assessment

The modes of assessing aspects of anxiety in children who are overanxious include structured clinical interviews, self-report questionnaires, parent and teacher ratings, direct observation and physiological measures (Strauss, 1988). Most research to date suggests that a multi-method assessment approach should be taken in assessing the needs of a child with OAD (Strauss, 1988).

Structured Clinical Interviews

Several structured clinical interviews have been devised recently that evaluate the presence and severity of overanxious symptoms in children. These include the Diagnostic Interview Schedule for Children (DISC) (Costello, Edelbrock, Kalas, Dulcan, & Klaric, 1984), the Diagnostic Interview for Children and Adolescents (DICA) (Herjanic & Reich, 1982), the Kiddie-SADS (Puig-Antich, Orvaschel, Tabrizi & Chambers, 1978), and the Interview Schedule for Children (ISC) (Kovacs, 1983). Each of these involves interviewing children and their parents individually with a standard set of questions covering all symptoms of psychopathology in children. Overanxious disorder is assessed by portions of each of these interview schedules.

The reliability and validity of these instruments are just beginning to be examined. Initial studies have found acceptable reliability using the DISC (Edelbrock, Costello, Dulcan, Kalas, & Conover, 1985) and the ISC (Kovacs, 1983). Adequate reliability was found when using the Kiddie-SADS (Strauss, Lahey, Frink, Frame, & Hynd, 1988). On the other hand, poor agreement between parent and child reports of anxiety symptoms using structured interviews has been found with children tending to report more anxiety symptoms than parents (Edelbrock et al., 1985). The validity of highly structured interviews seems to show promise in assessing anxiety in children (Costello et al., 1984).

Self-Report Questionnaires

Children's reports have been viewed as critical in assessment of anxiety or fearfulness. Several questionnaires have been developed that may be useful in evaluating the severity of self-reported anxiety in children who are overanxious, and measuring the effectiveness of interventions designed for children with OAD. One measure that the literature reports as being useful is the Children's Manifest Anxiety Scale-Revised (RCMAS) (Reynolds & Richmond, 1978). The RCMAS measures chronic levels of anxiety. In a study conducted by Strauss et al. (1988), children who are overanxious received higher scores on the RCMAS than did a normal control group.

A second self-report questionnaire, derived from the Wolpe-Lang Scale for adults, is the Fear Survey Schedule for Children (FSSC) (Scherer & Nakamura, 1968). On the FSSC children rate their degree of fearfulness. When using the FSSC results reveal that children who are overanxious do report more severe fears than children considered normal (Strauss et al., 1988).

The State-Trait Inventory for Children (STAIC) is a third frequently used self-report measure (Spielberger, 1973). The STAIC attempts to measure separately anxiety that varies across situations and anxiety that is stable across time and situations. As with other self-report measures of anxiety, children who are overanxious report higher levels of anxiety on both the state and trait scales of the STAIC (Strauss, Lease, Last, & Francis, 1988). However, studies generally have failed to support the validity of the state-trait distinction (Johnson & Melamed, 1979).

The Cognitive and Somatic State and Trait Anxiety Scale (CSSTAS) a self-report measure that evaluates cognitive and somatic anxiety (Fox & Houston, 1983). The CSSTAS is considered useful for evaluating children who are overanxious, because overanxious disorder is characterized by both cognitive and somatic forms of anxiety. Children who are overanxious showed elevated levels of both cognitive and somatic anxiety on this scale (Strauss et al., 1988).

Despite their wide acceptance and use, there are several features of self-report measures that limit the conclusions that can be drawn from them. These include: the child's unwillingness or inability to reveal negative characteristics (Glennon & Weisz, 1978), the small number of studies that have been conducted (Barrios, Hartmann, & Shigetomi, 1981) and the lack of specificity of situations that induce anxiety in the items included in most measures (Barrios et al., 1981).

Parent and Teacher Ratings

Parent and teacher ratings and checklists have been less evident in the literature as methods for evaluating anxiety, despite their infrequent use, many scales are available, including the Conner's Teacher Rating Scale (Conners, 1969), the Child Behavior Checklist (Achenbach & Edelbrock, 1983), and the Revised Behavior Problem Checklist (Quay & Peterson, 1983). The validity and reliability of these scales has been supported (Quay, 1983). In fact, children with OAD were rated by both their parents and teachers as demonstrating high levels of anxious-withdrawn behaviors (Strauss et al., 1988).

Direct Observation

Direct observations by parents, tecahers, etc... of anxious mannerisms and behavior by children who are overanxious may be very helpful. The primary challenge to using behavioral observations in assessing OAD or symptoms is being able to identify specific circumstances in which to observe anxious behavior since the anxiety displayed by children with OAD is not focused on one particular object or situation (Strauss, 1988).

Physiological Measures

Physiological responses associated with anxiety in children who are overanxious might be monitored. The value of this assessment may prove useful, because clinical experience with this group suggests that these children are not as aware of somatic symptoms associated with anxiety as they are of anxious thoughts (Strauss, 1988). On the other hand, numerous studies have failed to find significant connections between physiological states and other indicators.

Treatment Modalities

Behavior Therapy

Due to the absence of experimental evidence supporting the use of a specific intervention for overanxious disorder, several interventions will be addressed. Almost all the interventions discussed in the literature fall under the heading of behavior therapy. Behavior therapy incorporates the following approaches in working with children suffering from OAD: (a) relaxation techniques including muscle relaxation and visual imagery of pleasant scenes; (b) positive self-statements; (c) home-based token programs used to reward daily practice of skills learned and nonanxious behavior; (d) systematic desensitization; and (e) modeling.

Relaxation Techniques and Visual Imagery

In this treatment condition, children who are overanxious are first trained in deep muscle relaxation. Many relaxation programs have been developed such as; Kiddie QR (Stroebel, 1979; 1982), Relaxation Techniques (Ollendick & Cerny, 1981), biofeedback-assisted relaxation training (Zaichkowsky, Zaichkowsky, & Yeager, 1986). Children learn elements of progressive relaxation to ease tension in major muscle groups. Through a series of guided imagery exercises, children are taught to perceive rising tension in their bodies, and to start some method to counter this tension (Ragen & Hiebert, 1987). The children are also instructed in imagining a pleasant scene or experience to facilitate relaxation (Graziano & Mooney, 1980).

Positive self-statements

This technique is usually used in addition to a relaxation program. The child is asked to keep track of situations that induce anxiety, and thoughts that precede or accompany anxiety. These records are used to identify the child's beliefs that may be contributing to the child's anxiety state. The child then learns to rehearse positive self-statements that can replace the maladaptive thoughts (Beck and Emery, 1985). Probably the most frequently used cognitive approach with children who are anxious is verbal self-instruction (Graziano & Mooney, 1982).

Token Program

Token programs are also used in conjunction with relaxation and self-talk. Parents and/or teachers dispense tokens to the children based on how relaxed the child appears during the day. Tokens are accumulated and exchanged for rewards (Strauss, 1988).

Systematic Desensitization

Deconditioning is one of the most frequently used treatment strategies with children who are anxious (Ollendick, 1986). The child is asked to describe an example situation of when they are anxious. The child is then guided by the counselor in imagining and reexperiencing the anxiety and then terminating the scene and achieving relaxation. The aim of the strategy is to help the child gain control over the anxiety (Strauss, 1988). While these procedures appear to work with older children, younger children have difficulty in fully acquiring muscle relaxation and in being able to adequately image the anxiety producing element (Ollendick & Cerny, 1981).

Modeling

Modeling involves demonstrating nonfearful behavior in the anxiety producing situation and showing the child an appropriate response to use. After the demonstration, the child is instructed to model the performance of the model. This repeated rehearsal of appropriate behavior provides the child with functional coping skills (Ollendick, 1986). Thus, anxiety is reduced and coping skills are learned.

Psychotherapy

Because of their high level of character development, great motivation to please, and ability to understand and deal effectively with unconscious themes, children with OAD do exceedingly well in psychotherapy. They initiate themes of sibling rivalry, oedipal struggles, jealousies, and fear of loss of control. They tend to please therapists by their discussions of adults themes. Because these children fear rejection and loss of control, Compton believes it is most important that the therapist pay close attention to issues of consistency, and approval. When they feel accepted, such children allow themselves to give up their preoccupation with control and, instead, can experiment with regressive fantasy. Through these modes they can question their perfectionistic, achievement-driven attempts (Compton, 1982).

Personal Comments

I found that in the research I did there was very little mention of social cognitive development and its impact on the child's experiences with anxiety. Further study in this area might be beneficial to counselors as an aid to the nature of the anxiety, and thus, the best type of intervention to use.

Another area left void was the mention of the importance of developmental tasks, such as peer group relations, independence, responsibility, the concept of time, attention, frustration levels, and motivation. I feel all of these aspects operate in rendering anxiety in children.

As a counselor I would like to be able to have knowledge of a wide variety of interventions in dealing with anxiety. The current literature seems to be saturated with behavioral strategies. It would be refreshing to see some other theories express some of their views on childhood anxiety disorders.

Conclusion

Overanxious disorder is a commonly occurring phenomenon in childhood. Reliable diagnostic evaluation of overanxious symptoms appears to be best achieved by using multiple informants and multiple assessment tools. These include structured clinical interviews, self-reports, parent and teacher checklists, direct observations, and physiological measurements of anxiety. Treatment interventions for OAD have not yet been studied empirically, although some research suggests that the use of muscle relaxation and cognitive techniques may be helpful in alleviating overanxious symptoms. There is a definite need for further study examining the assessment and treatment of overanxious disorder in children.

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SCHOOL COUNSELOR'S ROLE IN DRUG EDUCATION PROGRAMS

by

Sandy Lemmon
Oregon State University
Department of Counseling

ABSTRACT

School counselors have been overlooked as a valuable resource when planning and implementing a successful drug and alcohol education program in schools. School counselors can be instrumental in educating their staff and the community in drug and alcohol issues, providing guidance lessons in the classroom and working with support groups in their schools. This article will discuss the role of the school counselor in developing a school wide program for dealing with substance abuse issues.

Introduction

Much has been written in the last decade about the abuses of drug and alcohol in American society (Brake, 1988, Budwick, Martin & Martin, 1988). Channing L. Bete Co. (cited in Ostrower, 1987) states:

> There are 100 million drinkers in the United States, and 10 million are chronic abusers; drunk drivers kill 28,000 people each year on the nation's highways; alcohol is associated with about 69% of all drownings; it is a factor in approximately 70% of all deaths and 63% of all injuries from falls; and $19 billion a year is lost to business, government and industry because of decreased work productivity caused by alcohol abuse. (p. 209)

As staggering as these statistics are, they do not tell the whole story. Alcohol abuse is not only destructive to the individual but also to the abuser's family and children. The effects of alcohol abuse are seen in the children who attend the nation's schools. Ostrower (1987) states:

> A counselor who works with youngsters in a public school often sees the reality of alcohol abuse translated into school problems for children, such as poor academic performance, low self-esteem, truancy, school phobia, aggressive or disruptive classroom behavior, withdrawal, depression, or difficulty relating to peers. (p. 209)

Students who are directly or indirectly affected by alcohol abuse are beginning to be recognized by the school system. Greater emphasis in the 1980's has been placed on drug education in schools then in previous decades. For example, research in the area of drug and alcohol has been done in conjunction with evaluating school programs (Garner, Martin, & Martin, 1989; Kim, 1988; Milgram, 1987; Sheppard, 1984; DeJong, 1987). Studies have been done on teacher training and education and substance abuse (Eiseman, Robinson, & Zapata, 1984; Newman, Mohr, Badger, & Gillespie, 1984). Research can be found on parent and community involvement with the drug and alcohol problem (Berdiansky 1988; Laudeman, 1984). Studies have focused on significant groups within the drug and alcohol field such as culturally different students (Murphy, 1984) and on children of alcoholics (Brake, 1988; Buwick, Martin & Martin, 1988; Davis, Johnston, DiCicco & Ornstein, 1985; Fisher, 1989; Newlon & Furrow 1986).

Extensive research in drug and alcohol can be found in the areas of prevention and intervention which provides a plethora of ideas and solutions to this multifaceted problem (Blount & Dembo, 1984; Gerler, 1988; Gerler & Moorhead, 1988; Gibson, 1989; Horan, Kerns & Olson, 1988; LeCoq & Capuzzi, 1984). Even with all this information, there are still many unresolved issues concerning drug and alcohol education. This is partly due to the lack of empirical research as suggested by Sheppard, Goodstadt & Willett, (1987):

> However, a great deal of drug education is based on what we feel is right and what our past experiences have told us. Research is not capable of keeping up with all the drug education that is going on and therefore, practitioners have to rely on other methods when making judgements about what they should do in their own particular situations. Until research can be adequately conducted that will show a causal link between drug education and drug use, we must continue to try different approaches and use our experience to guide us. (p. 200)

One resource that appears to have been over-looked until recently is the school counselor. It has only been acknowledged in the last several years that the school counselor is a valuable asset in developing a drug and alcohol program in the schools. Studies show that counselors could be used in a variety of ways depending upon the age of the students, the support of the staff and administration, and the nature of the problems existing within the schools (Brake, 1988; Oetting, 1988; Ostrower, 1987). The purpose of this article will be to present various ways in which school counselors could effectively be used in drug and alcohol education programs.

COUNSELOR AS EDUCATOR

It is expected that all school counselors have a knowledge base of human psychology and counseling theories. Ideally, counselors should also be well versed in identification of drugs, drug effects, disease concept, family roles and rules found in alcoholic homes, prevention and intervention resources available in the community (Berdiansky, Brownlee & Joy 1988; Fisher, 1989; Gerler & Moorhead, Oetting & Beauvais 1988). Counselors knowledgeable about substance abuse can be very instrumental in educating their communities, school boards, administrators and staff to the special needs of children affected in these areas. "Counselors need to be informed in order to consult effectively with parents, school administrators, and professional and community agencies about matters related to substance abuse." (Gerler & Moorhead, 1988, p. 139). Oetting & Beauvis (1988) state:

> Drug use by young people is rooted in personal attitudes and values and in the youth's relationships with the family and peers. Drugs are an integral part of a chosen life-style. Today's counselor must, therefore, be knowledgeable about drugs. If the counselor fails to

> consider the impact of drugs on students, a major area of adjustment is being avoided, and one that may be a potent force in the adolescent's life. (p. 15)

It is difficult to implement a drug and alcohol program and service children if there is a lack of knowledge and networking between the community and the schools. The school counselor could be a vital resource and a link between the school and the community. Brownlee, et. el. (1988) states:

> Elementary and middle school counselors who are aware of community agency programs of primary and secondary prevention can refer students and their families to such programs. . . .Counselors need to make every effort to use community drug action efforts to bolster their own drug education programs. Cooperation between school and community is an important step in the direction of eliminating drug abuse among youth. (p. 138)

COUNSELING STRATEGIES

When counselors have educated themselves and their school to the nature of the problem and the resources available in the community, it is time to look at implementing a drug and alcohol program in their school. It is important that the counselor be aware that a substantial number of students are raised in alcoholic and dysfunctional families. Many of these students are being subjected to chronic stress, parental conflict and have very low self-esteem (Brake, 1988; Budwick, et.el. 1988). Budwick, et.el. (1988) further states:

> Because the whole family is affected by the disease, the children are not given appropriate protection or limit setting. Affection that the child seeks is often given in uncomfortable or inappropriate methods. The children have no positive role models and their parents are often irresponsible and unpredictable. (p. 113)

Many of these students have been taught to not talk, not trust and not feel. Because of this, counselors need to be especially aware of how to deal with these children. Behaviors that the counselor should exhibit for these children are described by Buwick et.el. (1988):

> 1. Model Consistency. Most of these children live in homes in which rules are confusing, changes are abrupt, and parents are either too permissive or overly authoritarian. It is important that these children can depend on others, and they will perceive broken appointments or changed events as a sign of "giving up" on them.
>
> 2. Respond to Both Adaptive and Maladaptive Behaviors. Even more than other children, this child needs recognition for behaviors that are positive and contribute to the classroom. . . .Caring for children also means that if a child displays maladaptive behavior be breaking an established rule or limit, the counselor or teacher must set a consequence immediately.

> 3. Enable Children to Succeed. It's important to observe children in the classroom and in play areas and see if they interact with others. Counselors need to talk to children who are not involved and try to understand their rationale for noninvolvement. . . .If a child is resistant in talking with a counselor, the counselor should not give up, but should persist in trying to reach out to these children. (p. 114-115)

While it is assumed that most counselors are already using these techniques generally with students, it is especially important to be aware of these interventions when dealing with children from suspected substance abuse families. Other useful counseling techniques are to: validate the students feelings; add to their sense of normalcy; try to establish situations which encourage children to seek help; gain their trust. Counselors must always be aware of the difficulty of children to talk about such forbidden subjects (Brake, 1988).

GUIDANCE PROGRAMS

Guidance programs by school counselors are becoming more prevalent as a foundation to drug education programs in schools (Berdiansky, Brownlee & Joy, 1988; Bradley, 1988; Davis, Johnston, DiCicco, & Orenstein 1985; Gerler, 1988; Horan, Kerns & Olson 1988; LeCoq & Capuzzi 1984; Newlon & Furrow 1986; Ostrower, 1987). "Counselors can be instrumental in presenting materials and ideas through classroom guidance lessons that address the components of a successful prevention program" (Bradley, 1988, p. 102). Guidance programs can be used at elementary, middle and high schools and can be designed to fit the needs of the different age levels in these schools. Some programs are provided to "improve students understanding of alcohol and alcoholism" (Ostrower, 1987, p.208), while others delve deeper and have specific lessons as described by Berdiansky (1988):

> Lesson 1: Feelings. This lesson helps children recognize, identify, and accept the varied emotions they have each day.
>
> Lesson 2: Pharmacology. This lesson teaches children drug information specifically geared to their needs and comprehension.
>
> Lesson 3: Self-Awareness. This lesson helps children become more aware of their thoughts and emotions. Children also experience opportunities to feel positive about themselves. . .
>
> Lesson 4: Decision Making and Problem Solving. This lesson helps children understand that they have the power to make choices. (p. 136-137)

These lessons not only provide basic information, but also help discourage children and young adolescents from experimenting with drugs and alcohol.

Some guidance program goals are to identify and help support children who are coming from alcoholic homes.

Newlon & Furrow (1986), when describing a specific program state:

> The main purpose of the guidance sessions was to (a) help the children understand alcoholism as a family illness and all that it implied, and (b) help them see the necessity for every member of the alcoholic family to seek help regardless of what the alcoholic chooses to do. (p. 289)

Guidance programs in the classroom can be valuable in providing information and promoting prevention in a school's drug and alcohol program. They can also be helpful in identifying and intervening with children and adolescents who have already begun to experiment with alcohol and drugs. A school counselor is already in an ideal position to either organize or administer the guidance programs in the classroom.

INDIVIDUAL OR GROUP COUNSELING

The last piece of the puzzle in an effective drug and alcohol program for schools, is to provide counseling for students, either individually or in groups. This is typically done after the guidance lessons are completed. Newlong & Furrow (1986) state:

> After an extensive review of the literature, we concluded that the use of classroom guidance lessons on alcoholism and the family followed by an invitation to join a small group, which would deal with the subject on a more personal level, would be the most efficient

> and least threatening method of identifying children who came from alcoholic homes. (p. 288)

A children of alcoholics group would be rather small with only 6 to 8 students in a group. The students would meet together once a week with the counselor. Five areas that could be emphasized as described by Davis, Johnston, DiCicco & Orenstein (1985) are "First, you are not alone.... Second, your parents' drinking is not your fault....Third, alcoholism is a disease....Fourth, alcoholics can and do recover....Finally, you are a person of worth who needs and deserves help for yourself" (p. 359-360).

The counselor works with these students through the entire school year and also counsels them individually if necessary. Students from these groups are referred on to other groups within the school or the community if their needs change. "As these 'pieces' are put into place, children who receive support at one age level will be able to connect with similar services later and will know that help is available when they need it" (Davis, et.el, 1985, p. 362).

Groups could also be formed to help students either with low self-esteem or students who are new in the schools. Children with low self-esteem and children who are new and lonely may be more vulnerable and more likely to get involved with substance abuse activities. It is not unusual to discover that some of the students in these groups might also be children of alcoholics. These groups could be used to work on loneliness and low self-esteem with the hope of eventually referring them to a more specific group for ACOA'S. By offering other types of groups besides a children of alcoholic's group, it encourages more students to become involved. It also help to protect a student's anonymity by making it more difficult for others to identify the students who are attending the more problem-specific groups.

The last type of group the school counselor could work with are students in middle schools and high schools who have alcohol abuse problems. These are students who have been referred due to discipline problems concerning their use of alcohol and drugs, or students who are returning from substance abuse treatment centers and need the added support in schools to stay clean and sober. Ficklin, (1990) states:

> If kids who get into trouble are thrown back into exactly the same environment, they're likely to revert to exactly the same behavior that got them into trouble in the first place - that is, unless you've provided some kind of systematic follow-up program. Informal counseling might be most appropriate for students who were just beginning to experiment with drugs. But second or third offenders or students whose drug use necessitated attending a treatment center usually need special, in depth help. (p. 20)

A school counselor could provide in-depth help by getting these students into groups which address their special needs. These groups are facilitated by the school counselor or co-facilitated with other adults from community agencies, mental health facilities or persons familiar with 12-step programs.

PERSONAL REACTION

Based on the literature reviewed for this article, this author found it surprising that the drug education programs and the counseling techniques were not supported by any counseling or psychology theories. "Jungian personality traits" (Oetting & Beauvis, 1988) and "cognitive restructuring a la Ellis" (Horan et. el., 1988) were the only statements that referred to counseling and psychology theorists. These statements were used in describing personality traits of youth and not used as references in support of the article's techniques.

There seems to be extensive literature on drug and alcohol education, programs, community action and group work with children from alcoholic homes. In some of these articles, references to school counselors and how they may be helpful are scattered sparingly throughout the information. This author has compiled, organized and refined the material based on personal and professional experiences gained in the substance abuse area. This article reflects the biases of this author and presents her idea of a workable drug and alcohol education program that incorporates the help of a school counselor.

SUMMARY

School counselors, until recently, have been over-looked as a valuable resource when defining and planning drug and alcohol education programs. There are many components to a successful program and school counselors should be a part of the planning and implementation of that program. The needs of students who are directly or indirectly affected by alcohol cannot and should not be minimized by the school counselor, the staff and the community. Drug and alcohol intervention in the school needs to be a joint effort by everyone to develop and organize a well thought out and well planned educational program in dealing with substance abuse. A school counselor is just one piece of the puzzle, but a very important one when developing a successful drug and alcohol program in a school.

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LEARNING DISABILITIES AND COUNSELING INTERVENTIONS

by

Cindy Parke
Oregon State University
Department of Counseling

LEARNING DISABLED: DEFINITION AND ATTRIBUTES

The term learning disability is studied and referred to frequently by professionals in the fields of psychology and education. Research and treatment has been hampered, however, by controversy not only about its causes, but its definition as well. Most commonly, students are designated learning disabled when they demonstrate normal to above normal potential (generally measured by the WISC-R) and are working below the expected grade level in reading or math. The discrepancy between potential and achievement must be severe in order for the child to qualify. Measurement of this discrepancy differs from state to state, but usually entails a minimum of 1.5 years difference. The expected grade level is established using the results of the IQ test. Normal or average intelligence criteria also differs from state to state with the lowest scores acceptable ranging from 80 to 90 (Oliva & La Greca, 1988; Shelton, Anastopoulos & Linden, 1985; Wojnilower & Gross, 1988).

The National Joint Committee for Learning Disabilities stated that:

> Learning disabilities is a generic term that refers to a heterogeneous group of disorders manifested by significant difficulties in the acquisition and use of listening, speaking, reading, writing, reasoning or mathematical abilities. These disorders are intrinsic to the individual and presumed to be due to a central nervous dysfunction. (Hammill, Larsen, Leigh & McNutt, 1981, as cited in Margalit & Shulman, 1986).

The concept to be emphasized here is that the disorder is intrinsic to the individual. Poor school achievement due to external factors such as socio-economic status, school non-attendance or lack of familial support alone do not contribute to the classification. Since 1975 when Public Law 94-142 mandated school systems to provide free appropriate public education to all handicapped children these distinctions have gained in importance (Smith, 1979). More children are being identified and yet schools are finding themselves with tighter budgets to meet these expanding needs. Questions arise about who do the schools have to serve. Does a child qualify for services who is working less than 1.5 years below chronological (based on age) grade level, but greater than 1.5 years below his/her expected grade level based on IQ scores? Considering the vague, yet powerful state of the law, the definition of learning disabled is likely to be decided in the court system before there is agreement amongst professsionals.

Review of the literature does reveal some consistent themes in regards to learning disabilities. Boys out number girls by a ratio exceeding 5 to 1 in special programs (Broseau & Locke, cited in Wojnilower & Gross, 1988). Research shows this is partially due to teacher biases. Teachers are often annoyed with the aggressive behavior boys exhibit in the classroom (Phipps, cited in Miles, 1986). This tendency, plus the greater societal concern aroused when a boy has learning problems (men are still considered the major wage earner) means boys are more often given a higher referral priority (Schlosser & Algozzine, cited in Miles, 1986).

Etiological theories focus on a diverse array of possible causes of this dysfunction. The dominant theory to emerge out of all the controversy dates as far back as 1937 when Orton proposed that failure to establish brain hemisphere dominance was a major factor in dyslexia (Fried, cited in Miles, 1986). Girls establish cerebral dominance for language two to three years earlier than boys, thus, they are at an advantage during the early grades in learning to read.

Although some learning disabled children show no sign of maladaption, there is a growing body of literature that indicates many of these children have greater difficulty establishing and maintaining interpersonal relations than the nondisabled. An inability to "identify and recognize the meaning and significance of the behavior of others" (Wanat, 1983, p. 35), puts them at a social disadvantage. Before school even starts they may see themselves as failures.

Social competence includes more than just knowing the rules and strategies to employ; appropriate timing and understanding of social goals (why they should behave in a certain way) is essential. Assertiveness is an excellent example of this issue. Training learning disabled children to be assertive is insufficient if not complimented with training in discrimination or appropriateness (Wojnilower & Gross, 1988). Studies suggest that learning disabled children appear to develop metacognition, or knowlege about knowledge, at a slower rate than the nondisabled (Oliva & La Greca, 1988).

Margalit & Shulman (1986) presented evidence that learning disabled children often exhibit high trait anxiety. This is a relatively stable personality characteristic defined as a series of responses indicative of a lower expectancy of success in valued need areas (Tobias, 1979). They hypothesized that this interferes with the learning disabled child's ability to perceive events accurately and adapt to new situations. This high anxiety, matched with demonstrated relatively low levels of autonomy (the desire to control one's own actions) (Margalit & Shulman, 1986), places this population at risk. First, as Margalit and Shulman point out, these children are vulnerable to excessive help and support which creates continuous dependence on adults or a sense of helplessness. Secondly, they are vulnerable to conformity to peer pressure. Results of recent studies indicate that "although the students with learning disabilities and achieving classmates did not differ in their estimates of likely conformity to respond to peer pressure to engage in prosocial behaviors, the subjects with learning disabilities rated themselves more likely to agree to engage in antisocial activities" (Bryan, Pearl & Fallon, 1989, p. 458).

Much has been written about the communication skills of children with learning disabilities and their infuence upon social success. Raskind's (1983) and Grogan's (1988) studies on nonverbal behaviors in learning disabled children found very little difference between them and other children. This tends to support Jorm, Share, Mathews & Maclean's contention (cited in Grogan, 1988) that "children of above average intelligence with reading problems are not less socially skilled than adequate readers" (p. 367). Still other researchers maintain that these children do significantly more poorly (Bryan & Pflaum, cited in Mathinos, 1988; Noel, 1980). As suggested by Mathinos (1988), research needs to avoid gross comparisons and focus on subtle differences in conversational strategies.

As mentioned earlier, research in the causes and effects of learning disabilities has been hindered by design problems. Good experimental research is grounded in validity - the instrument tests what it is supposed to test. Since mental states or events are not directly observable, they must be measured indirectly. Variations in question format and wording style have repeatedly presented difficulties in evaluating the meaning of data (Whitley & Frieze, 1985).

The exact use or definition of words complicates matters further. It is surprising, for example, that researchers rarely distinguish between students with linguistic learning disabilities and those with nonverbal learning disabilities (NLD). While a linguistic disability centers around auditory discrimination, spelling and reading issues, the NLD child has visual-spatial-organizational problems as specifically seen in math and psychomotor clumsiness. Although the NLD students have well developed rote verbal skills, they have marked deficiencies in picking up or understanding nonverbal information of any sort. This leads to problems in social perception, social judgement and social interaction skills. People (including children) with the NLD syndrome are considered particularly at risk for depression and, in turn, for suicide (Rourke, Young & Leenars, 1989). It would seem that this distinction is significant enough to identify and consequently separate the specific population being studied and/or counseled.

A history of academic failure is an established characteristic of the learning disabled population. It is also widely believed that negative affective responses are another major characteristic. Affective reactions to success and failure include self concepts, locus of control beliefs and academic performance expectations (Rogers & Saklofske, 1985).

Most professionals assume a child's self-concept is damaged by handicapped labels and special-class placements. Surprisingly, some studies show that the children in these classes most often compare themselves to each other rather than the larger school system and are able to maintain a high sense of self worth (Coleman, 1985). Other studies of adolescents support this viewpoint and suggest that by that age students have managed to find ego-enhancing experiences outside of school (Silverman & Zigmond, 1983). At most risk are those students from families with high socioeconomic status. It appears they are most aware of not meeting their parent's typically greater expectations for success (Smith, Zingale & Coleman, 1978). Still more studies support the traditional belief that repeated academic failure will result in negative self-concepts (Jacobsen,Lowery & DuCette, 1986). It is difficult, in my opinion, to imagine feelings of helplessness, anxiety, social isolation and failure having no impact on an individual's self-concept.

Locus of control refers to where people believe the decision making factors in their lives are located. Rotter began exploring this idea in 1954 (Swick & Graves, 1986) as an outgrowth of social learning theory. He hypothesized that "internals" believe they themselves are the source of control. "Externals", on the other hand, believe that reinforcements are not under their personal control, but due instead to luck, chance or fate (Swick & Graves, 1986). The concept has been broadened to include a continuum illustrating various combinations of the two extremes (Gilmore, cited in Swick & Graves, 1986). Locus of control beliefs are developed and adjusted by life experiences and provide a basis for decision making. Any locus of control orientation, once established, has a self perpetuating capacity. The individual acts in such a way as to create an environment which supports and reinforces his/her belief system. This concept is frequently applied to children with learning disabilities.

The basic scenario supported by research begins with learning disabled children experiencing repeated academic failures early in school. The failures "occur at a high rate, over long periods of time and across a variety of tasks and teachers" (Licht, 1983, p. 483). In response to this the children lose faith in their intellectual abilities and come to believe they are incapable of surmounting these problems. Because they believe they can do nothing to change their situation, the children reduce their efforts to achieve. This in turn increases the probability of failure, which strengthens the original perception of ability. Thus, academic performance expectations are continually kept low (Adelman & Taylor, 1983; Chapman, 1988; Licht, 1983; Rogers & Saklofske, 1985, Shelton, Anastopoulos & Linden, 1985).

Learning disabled children have demonstrated perceptions of internal control in research. Sorrowfully, however, it is most often in response to failures. They take more responsibility for their failures than non-learnining disabled students and have more failures to be responsible for. In turn, they are more likely to externalize their successes (Jacobsen, Lowery & DuCette, 1986).

It is important to clarify definitions and review the literature in regards to any population before discussing counseling or educational treatment plans. Much time, energy and money is lost pursuing inappropriate goals. The evaluation of any program must start with the validity of its needs assessment process.

In the first half of this paper two broad areas of possible difficulty for children with learning disabilities have been identified. First is the intra-personal realm. This includes self-esteem, locus of control and anxiety issues. The second area is that of interpersonal relations. Autonomy, peer pressure and adaptability are all negatively influenced by poor social skills. It is the treatment of these concerns that the second half of the paper will address. Academic performance will be considered only in so far as it influences the above.

COUNSELING INTERVENTIONS

THROUGH THE TEACHER

The typical child spends seven hours, five days a week in the school environment. For most children, the dominant factor during the school day is their teacher. The teacher is the person with power, setting the pace and tone of academic and social interactions. Teachers traditionally set up classroom-based learning situations which demand behaviors reflecting their preferences. These include high levels of persistence, adaptability and approach tendencies (socially outgoingness), matched with low distractability (Lerner, Lerner & Zabski, cited in Cardell & Palmer, 1988; Martin cited in Cardell & Parmar, 1988). The results of a study by Cardell and Parmar (1988) indicate that teachers of learning disabled students rate their students' behavior as low in the first three dimensions and high in distractability.

Add to this information the research which reveals that "teachers form negative pre-expectations of learning disabled children before instruction takes place" (Reid & Hresko, p. 105, cited in Cardell & Parmar, 1988) and one could easily foresee negative dynamics in the classroom. The child who is already dealing with low self-esteem, high anxiety and social confusion may not find him/herself in the necessary nurturing situation. As suggested by systems theorists, the feedback loop between teacher and child helps the dysfunctional behaviors persist (Fine & Holt, 1983). For example, the locus of control orientation the child brings to school invites the teacher to behave in such a way as to reinforce the child's expectations (Galejs & Heglund, 1982).

The school counselor is in an excellent position to influence this possible spiral downward. Pre- and inservice training programs for teachers need to cover social and emotional characteristics, as well as the cognitive aspect of teaching children with learning disabilities. They can be used as a tool by the counselor to reframe the entire school's perception of these student's behavior in a positive and functional way. As teachers become aware of their perceptions and their impact on students, more ways to adapt classroom approaches to fit this special student will likely be developed.

Strategies for improving self-concept and motivation in the classroom will not be covered within the scope of this paper. It is sufficient to say there is a great deal that can be done to improve the cognitive and affective learning experience in any classroom. Much of what would be beneficial to the learning disabled student, would benefit the average achiever as well (Adelman & Taylor, 1983).

It is common for adults (parents and teachers) who work with the learning disabled child to "catch" the student's feelings of anger, frustration, defeat and helplessness. Teachers can start the day feeling cheerful and competent, and in a short time feel depressed and exhausted. It is for this reason Smith (1979) recommends the school counselor or psychologist meet with the teachers of learning disabled children, individually and in groups, and talk about their feelings. This is instead of, or in addition to, meeting directly with the students. The idea is that teachers are on the frontline and influence the child daily. Hence, counseling interventions with the teacher can be viewed as interventions on behalf of the child as well.

The approach to the above mentioned counseling process for teachers depends upon the theoretical outlook of the counselor. The cognitive approach would entail clarifying and checking out the teachers assumptions about the classroom experience. Whereas, a person-centered counselor would consentrate on listening to the teacher's feelings. Regardless of the theory base, however, the intent is to provide support and a place to process for the teacher.

THROUGH GROUPS

Group counseling for students has gained popularity in the schools in recent years. It is effective, efficient and easily conducted by school counselors. Omizo, Cubberly and Longano (1984) studied the effects of a group counseling treatment for eliminating a self defeating behavior developed by Cudney and expanded by Chamberlain (as cited in Omizo, Cubberly & Longano,1984). They applied the mode to a group of eight to eleven year old learning disabled children.

The study showed that children who participated in the counseling groups had significantly higher scores on aspiration and internal locus of control, as well as lower levels of anxiety, in comparison to the control group. The group experience encouraged them to set higher, often more appropriate goals, to be more emotionally stable and to perceive their ability to change unwanted aspects of their lives. Although not an item directly measured, this author believes the group experience may increase autonomy as well as the child's actual and perceived skills increase.

Omizo and Omizo (1987) repeated this study using different tests and found that the group counseling sessions again resulted in higher self-esteem and more internal locus of control perception. Research supports the use of groups with populations with external control orientations. Nowicki (1982) found that when a situation called for team cooperation, externals performed on a comparable level to internals and significantly higher than other externals in a competitive situation. Social cues appear to facilitate their performance.

The purpose of the group treatment was to demonstrate to the students that they have control over their own self-defeating behaviors. It was hoped that the elimination of one of these behaviors would provide a sense of and reduce the barriers to success. The groups that Omizo and Omizo studied had approximately eleven students, a trained facilitator and met for one and one half hours, for eight weeks. Each session had a specific agenda:

Session one - each participant selects a self-defeating behavior that he or she desires to eliminate. A discussion follows on how each participant learned, and continues to perpetuate, the self-defeating behavior.

Session two - each participant identifies how he or she denies full responsibility for the self-defeating behavior by engaging in negative self-labeling or by blaming other individuals or circumstances.

Session three - each participant recognizes short-term and long-term penalties paid for doing the self-defeating behavior, the resulting discomforts, and how the penalties or consequences can be minimized.

Session four - each participant recognizes the personal choices made to activate and perpetuate the self-defeating behavior and explores the choices that would need to be made to abandon the self-defeating behavior.

Session five - each participant identifies negative techniques currently being used to activate the self-defeating behavior choices and identifies positive techniques that need to be developed to eliminate the self-defeating behavior.

Session six - each participant discusses the fears he or she has related to giving up the self-defeating behavior.

Session seven - all participants engage in a 15-25 minute guided imagery session in which the children imagine a barrier to their eliminating their self-defeating behavior and then imagine surmounting the barrier and destroying it. The session also includes a discussion of the barriers and how the participants can overcome those barriers.

Session eight - all participants discuss the group process (Omizo & Omizo, 1987).

This basically cognitive approach to behavior change in groups is quite intriquing to me. I see a great deal of potential in its expansion to a long term experience. The hidden agenda for any group appears to be social skills training. Groups such as this would be an excellent place for students, under the guidance of the facilitator, to practice and adapt constructive social behaviors. My only reservation is in emphasizing internal control for a group who already owns so thoroughly its failures. There are parts of their experiences that they cannot control, that trying harder will not change. These are individuals with possi-ble minimal brain dysfunctions, not laziness. I prefer to see the emphases placed on ways to adapt and utilize (or control) one's strengths, rather than absolute control in general.

Another form of group experience is a formal social skills class. These can be conducted within a regular classroom or the smaller, more intimate special education classroom. The purpose is to enhance social awareness and the appropriate use of social strategies. Learning disabled youngsters usually need to learn to generate more alternative solutions and to try again when the initial strategy fails (Oliva & La Greca, 1988). It is my belief that the school counselor is the logical initiator and facilitator of such a class. Although many teachers would be qualified, their general preoccupation with academics could reduce the time devoted entirely to social skills and emotions. School counselors are also more likely to be in a position to justify expenditure of time and money this way.

One such program studied by Wanat (1983) showed scores on self-concept and social perception tests improving after only sixteen weeks. Sixteen units of the Innerchange Human Development Progam were presented one hour each day, five days per week. The format consisted of one instructor and fifteen students (adolescents) sitting in a circle with verbal discussion being the primary form of interaction. The units included activity cards with a topic statement and discussion questions, filmstrips and experience sheets for each student to fill out and possibly share. It was expected that the long term result of the class would be a positive influence on academic performance.

THROUGH THE FAMILY

A new approach to learning disabilities as illustrated by trends in the research literature is one that incorporates a contextual, interactional view of the family. Research indicates that the families of children with learning disabilities experience stress and that an inability to cope wiht that stress perpetuates and intensifies the learning difficulties (Fish & Jain, 1985). The new focus is on the families with learning disabled children who progress socially and academically and how they interact. What are the healthful factors in their family ecology?

Through clinical investigation, Stoll Switzer (1990) has identified four major factors commonly observed in these successful families. Factor one is the inability to deny early signs and symptoms of the disability. Interestingly, school professionals' behavior is often adverse to this process, putting the parents off while their children "outgrow the problem" (Faerstein,1986). As parents persevere in exploring the situation, they are often negatively perceived by these same professionals and given labels such as maladaptively angry. Inability to deny the signs is seen as an indictor of acceptance of the learning problem.

Factor two is an appropriate level of engagement around school or school like tasks. These parents do not disengage due to frustration nor over protect the child. Instead they use modeling and prompts to facilitate progress.

An authoritative parental discipline method is the third factor. This is opposed to an authortarian, arbitrary method which does not develop the child's internal controls. Permissive, rejecting or laissez faire styles were considered unsuccessful as well. The learning disabled child needs clarity in regards to rules both in the home and in the school.

Factor four includes the role of the identified child within the family context. Is s/he the family pet or scapegoat? Supportive family systems allow for role change to accomodate changes in maturity and achievement.

Counseling interventions can facilitate the development of functional family sytems in many ways. The four interventions detailed below fall under the general umbrella of systems theory. Working with family systems is a logical step when recognizing the importance of family dynamics to the learning disabled child.

The crucial first intervention is that of assessment. Acceptance of the problem cannot be accomplished until the issue is identified. An expanded concept of assessment goes beyond identifying the child to include the entire family. Interviewing the whole family not only gives the professional more direct information about family patterns and expectations, but increases client satisfaction and follow through (Freund, cited in Fish & Jain, 1985). Assessment should also include: 1. the family's past history with the school, 2. economic, social and stress increasing factors and 3. cultural factors to highlight differing expectations (Fish & Jain, 1985).

The counselor is cautioned not to focus on the specific behavior of one family member outside of the larger family picture (Amerikaner

& Omizo, 1984). The meaning of each member's behavior can only be understood in context. As was mentioned before, the labeling of parents when the counselor has insufficient information can be detrimental to the cause. The traditional view of the over involved mother or disengaged father is irrelevant without knowing actual behavior.

Clinical observations suggest parents are eager for honest, forthright communication about the assessment findings (Stoll Switzer, 1990). A clear, intelligible diagnoses more often produces relief as well as acceptance, instead of denial (Faerstein, 1986). Fish and Jain (1985) describe the counselor's task in the assessment and acceptance process as to normalize or deintensify the problem by reframing perception of it by the family. Joining - being the glue that holds the therapeutic process together is another. They suggest this be done by:

> 1. making the school system accessible to the family, 2. actively enlisting the parent's help in the process of assessment, 3. sharing the formal test results with the family in language that the family can understand, and 4. respecting and strengthening family boundaries and elaborating on family competencies in dealing with the situation. (p. 594)

Short-term family counseling is an infrequently used intervention due to a perceived lack of time and skills on the part of the counselor. Referral of the family to a longer-term, more intensive treatment program is more often the case. Provided the counselor feels comfortable and competent in this mode, however, short-term family counseling can be an excellent forum for shifting the problem from the child to include the situation. It would be a very appropriate place to reframe perceptions of family behavior and attitudes (Fine & Holt, 1983).

Friedman (1978) used the term "parent-tutor psychotherapy" to describe the modeling of a positive tutoring process by the therapist for the parent. The technique is more than an educational experience, as the participants take time to reflect and interpret their feelings. As the parent takes over the tutoring role the therapist (or counselor) acts as a supportive coach. Both parent and child are then able to carry out their roles with increased confidence.

The last intervention which will be discussed in this paper is that of a parent's group. These meetings can be ongoing or for only three or four sessions. Both education and support are emphasized regardless of the time involved. Information on the cognitive, social and emotional implications of a learning disability for the family as well as the child is shared. Clarifying basic definitions and discussing strategies for working with the school district is also appropriate. Specific parenting skills are often sought after by these parents, including ways to support the child and improve his/her self-image.

Parent groups are an efficient use of a counselor's time because of their effectiveness. Families with mild to moderate difficulties typically experience the sessions as extremely helpful and show signs of family growth (Stoll Switzer, 1985). Self-help groups are gaining professional recognition for their therapeutic value. Social support has been shown to buffer the psychological impact of life's stresses (Thoit, cited in Gazda, 1989, p. 247). Social support given by someone in a similar situation is particularly effective because of the increased credibility of the helper (Silverman & Smith ,cited in Gazda, 1989, p. 247). The most therapeutic aspect of the experience may be the opportunity to change roles and become a helper (Riessman, 1965; Rappaport, cited in Gazda, p. 247). Parents are empowered by the process of sharing with each other.

There is so much more that could be done to help learning disabled children and their families. One to one counseling, bibliotherapy, biofeedback and relaxation training are just a few of the counseling techniques yet to explore. It is my opinion that all of these have a place in the counseling spectrum. My personal experience as a parent of a child with learning disabilities attests to the need for these forms of support and to their effectiveness.

CONCLUSION

In this paper the term learning disability has been defined and, based on a review of the literature, a list of the typical attributes of the learning disabled child discussed. Counselor intervention possibilities involving both the school and the family were also explored. Directly and indirectly, they have all dealt with the intra-

and inter-personal issues complicated by a disability. In closing, it is important to re-emphasize the need for school counselors to take an active role in the learning disabled child's experience of school. They are in an optimum position to coordinate the collaboration of home-school efforts, to facilitate communication between all parties, and to educate society in general.

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CHILDREN OF DIVORCE:
An Intervention Program for Elementary Schools

by

Christie M. Plinski
Oregon State University
Department of Counseling

Children of Divorce: An Intervention Program for Elementary Schools

Introduction

More children than ever before are affected by parental divorce. Though the statistics are steadily changing, it has been estimated that 22% of all children 18 and under live in a single parent home (Tedder, Scherman & Wantz, 1987). Alison Clarke-Stewart (1989) further suggests that in the United States, one school child in three have parents who are divorced and that of these children, 30% live in stepparent families while the other 70% live alone with a single parent. Statistics show that in 1910 only 1 divorce occurred in 1000 marriages in the United States, while in 1980 those numbers had increased to 5 in 1000 (U.S. Bureau of Statistics, 1980 as quoted in Scherman & Lepak, 1986).

Without question, divorce is a problem affecting millions of elementary age school children. With the incidence of divorce increasing in the United States, the number of children coping with the effects of divorce is reaching alarming proportions and must be reckoned with in the schools. In fact, Hammond (1979) believes that one of the fastest growing concerns of youth today is the possibility of parental separation. Studies suggest that this family trauma can contribute to behavioral, emotional and learning difficulties for the child struggling to cope with the change (Hammond, 1979; Guidubaldi, Cleminshaw Perry, & Mcloughlin, 1983; Wallerstein & Kelly, 1980). School counselors interested in the total child must address these issues and find effective means of helping the child through the bereavement associated with divorce (Hammond, 1979).

Although there are many variables affecting a child's readjustment rate, school counselors are faced with the arduous task of implementing interventions designed to assist children in learning to cope with parental divorce. Their task is broad but must include furthering the awareness and sensitivity of administration and staff to children coping with parental divorce as well as providing support and assistance for children through this stressful family change. This report will look at the effects of divorce on elementary age school children from a developmental perspective, specifically those children between the ages of 9 an 12. It will explore the school's role in helping children of divorce cope with the trauma of divorce. Finally, this report will examine specific school interventions, namely suggested classroom activities as well as children's divorce groups.

Population

Children of divorce must not be considered an individual entity or a diagnostically significant category (Wilkinson & Bleck, 1977). For the most part, they are normal, healthy children who have been confronted with an extremely stressful situation. Statistically, the rate of divorce has doubled in the last 20 years, yet studies show that initial shock reactions to parental divorce have not changed (Hulka & Weingarten, as quoted in Wallerstein & Kelly, 1980). Though often living in unhappy, tension-filled homes, parental divorce still hits most children with dramatic impact.

The literature conveys mixed messages about the effects of divorce on children. Research shows that children suffer, and sometimes suffer severely, from these traumatic family changes (Clarke-Stewart, 1989; Guidubaldi, et al 1983; Hammond, 1979; Scherman & Lepak, 1986; Wallerstein & Kelly, 1980). The impressive consensus of these studies is that although the reactions may not be long-term nor perhaps observable in behavioral changes, divorce clearly results in negative stresses for children and parents (Guidubaldi, et al, 1983). Reactions to divorce may be observed in school by acting-out behaviors, decline in academic achievement and perhaps strained relations with peers as well as teachers. Though children of divorce share the potential for developing adjustment problems, divorce does not automatically mean that problems will occur (Clarke-Stewart, 1989; Tedder, Scherman & Wentz, 1987; Wallerstein, 1983). In either case, divorce is clearly a painful experience for children.

Several factors seem to have an impact on the rate of adjustment for children. Many research efforts strongly implicate the importance of timing of the parental divorce on the child's life (Guidubaldi, et al, 1983; Kalter & Rembar, 1981; Scherman & Lepak, 1986, Wallerstein & Kelly, 1980). Gardner (as cited in Kalter & Rembar, 1981) states that: "There are some who believe that there are special ages at which children are particularly vulnerable to divorce" (p.86). This paper will specifically look at the effects as they relate to elementary age school children, specifically those between the ages of 9 and 12.

Effects

Wallerstein (1983) suggests that children of divorcing parents face this process as a pivotal point in their childhood, similar in intensity to the experience of a child facing the loss of a parent through death. Certainly, loss is a factor in both instances. Divorce is a painful, stressful transition even when it is the best solution to irreconcilable marital difficulties. Because of the traumatic nature of the event, children of divorce must learn to cope with additional stresses and specific emotional threats that must be resolved. Often children living with a single parent must additionally adapt to major changes in external living conditions. For school age children already coping with the customary tasks of development, adjustment to divorce is a stressful transition which creates an added burden in the development process. Research is contradictory as to the exact long-term effects of this additional burden, but Wallerstein (1983) believes that the divorce remains for many children, the central event of their childhood, casting a long shadow over their growing up years.

A review of the literature reveals that a child's symptoms to the initial shock of divorce include shock, depression, anger, shame, fear and insecurity (Guidubaldi, et al 1983, Wallerstein & Kelly,1980). For example, Wallerstein & Kelly (1980) found that:

> Anger played a significant role in the psychological life of 23 percent of the children and adolescents, who were not coping well. Most of the anger was defensive and reflected the underlying fear, sorrow, and sense of powerlessness of these youngsters (p. 71).

The Wallerstein & Kelly study (1980) further claimed that even after the initial impact of the divorce had lessened, children of divorce continued to struggle with unhappiness, diminished self-esteem and anger and sometimes hampered the full potential of their development. Longitudinal studies typically reflect that the initial stressors, namely separation phobias, anxiety reactions, ego regressions, sleep disturbances and acute mourning, related to the divorce abate within the first 18 months following the divorce (Wallerstein, 1983). Yet, these children continued to struggle with lower self-esteem than those whose parents remained together. This condition often follows a child into adulthood and seems to be connected to the age of the child at the time of parental divorce (Guidubaldi, et al, 1983; Hetherington, Cox & Cox as cited in Guidubaldi, et al, 1983, Kalter & Rembar, 1981; Parish, 1981; Wallerstein & Kelly, 1980).

Although the stress and subsequent adjustment to the divorce is difficult for all aged children, many researchers agree that children aged 9-12 are often more upset and exhibit greater disruption in school performance than children at any other level (Clarke-Stewart, 1989; Tedder, Scherman & Wantz, 1987). Latency age children seem to represent a milestone in development as this is a period of rapid growth for children. Children of this age at the time of parental divorce, understand more of what is happening in their lives than younger children. They yearn for the lost parent, they hurt more, they feel rejected and torn in two directions (Clarke-Stewart, 1989). In an early study, Kelly & Wallerstein (1977) identified the tendency in early latency age children, for "open suffering, immobilization and their vulnerability to regression" in the period following their parent's divorce (p. 26). Because of their age, these children seemed caught in a developmental trap: unable to utilize denial as effectively as younger children, they were also unable to mobilize themselves as effectively as older children. The literature seems to further suggest that the feelings most often experienced by these children are loss, rejection, shame, abandonment and intense anger over the divorce (Clarke-Stewart, 1989; Thompson & Rudolph, 1988). More than any other age group, children 9-12 seem to have greater difficulty finding relief from sorrow associated with parental divorce.

In conjunction with studies identifying adjustment difficulties in this aged child, Kelly & Wallerstein (1977) claimed that nearly one-half of the latency age children evidenced striking behavior and affect changes in the school setting. They further suggested that often the open suffering and anguish, their awareness of the realities of divorce, combined with immature ego structures, made for difficulty in integrating the painful experience. Most children of this age seemed to have trouble talking about divorce.

Wilkinson & Bleck (1977) theorize that divorce is an external event in the child's life, not an internal affliction, and that behavioral reactions of children to this emotional trauma are varied and often difficult to identify. Landis and Nye (as cited in Wilkinson & Black,1977) address the multi-variate reactions of school age children of divorce by suggesting that some children tend to withdraw from their environment, while others aggress against it or remain seemingly unchanged. Some statistical studies (Scherman & Lepak, 1986) reinforce the view that there is a direct link between broken homes and troubled children, while other studies find no direct connection (Burchenial, as cited in Scherman & Lepak, 1980). AlThough the data is inconclusive, some researchers also suggest that the child coping with the stress of divorce evidences a higher incidence of academic difficulty, often linked with a troubled home environment (Guidubaldi, et al, 1983; Wallerstein & Kelly, 1976).

In a long-range study on the effects of divorce on children, Judith Wallerstein (1983) has suggested that regardless of the specific circumstances surrounding each child, that many years may be necessary to effect the changes surrounding divorce. She further states:

> The reorganization and readjustments that are required of the child of the divorcing family, namely the tasks that need to be addressed, represent a major addition to the expectable customary tasks of childhood and adolescence in our society. In this view, the child of divorce faces a special set of challenges and carries an added burden (p. 231).

As a part of her study, Wallerstein identified six psychological tasks, which were shaped by perceived threats posed by the divorce process, that must successfully be resolved in order to achieve closure to the divorce experience. As Wallerstein outlined them, they fall into an enfolding sequence with varying time spans attached for the accomplishment of each.

Task #1. Acknowledging the reality of the divorce.

This task is generally addressed by the child immediately at the time of parental separation and then optimally resolved during the first year. A major divorce related obstacle in this stage is tied to the child's terrifying fantasies of parental abandonment and disaster and clearly connected to age appropriate development of the child.

Task #2. Disengaging from parental conflict.

As with the first, this task needs to be addressed immediately at the time of decisive separation and optimally resolved during the first year. This task involves returning to the customary activities and relationships at school and play and to do so with a capacity for learning and appropriate interests separate from family conflicts.

Task #3. Resoultion of the Loss

Mastering this task is perhaps the single most difficult task imposed by the divorce and may possibly remain unresolved for many years. This task requires that the child overcome a profound sense of loss, rejection, humiliation, unlovability and powerlessness.

Task #4. Resolving anger and self-blame.

The nature of divorce revolves around voluntary human choice; because of this conscious choice on the part of one or both partners a child may subsequently fix self-blame for the failure of the marriage. Resolving the related anger allows the child to eventually bring mastery to this task.

Task #5. Accepting the permanence of divorce.

Peculiar to divorce is the tenacity of the reuniting fantasy. It typically takes a long period of time for the child to relinquish this fantasy and to bring closure to the divorce process.

Task #6. Achieving realistic hope regarding relationships.

This task has been identified as the most important task for the child and for society. Mastery of this task typically occurs sometime during adolescence and requires the acquisition of confidence in the child's lovability and self-worth.

Successful mastery of these developmental tasks seem crucial in the overall adjustment of the child coping with parental divorce. Wallerstein (1983) believes that the resolution of these tasks provide a sense of closure to the divorce experience, allowing for a sense of "well-earned independence and pride and an intact capacity to trust and love" (p. 242). She further cautions, however, that even when these tasks are successfully resolved, there may remain for the child of divorce issues of sadness, anger, and anxiety about the potential unreliability of relationships which recur throughout adulthood.

Other factors within the child's life that may promote or encourage the mastery of these tasks involve the child's immediate environment and support systems. An analysis of the literature supports the need for a child's on-going stable, loving relationship with both parents, between whom friction has largely dissipated (Clarke-Stewart, 1989; Thompson & Rudolph, 1988; Wallerstein & Kelly, 1980). The elementary school counselor can play a significant role in providing support for children of divorce within the familiar environment of the school. Recognizing that all children, in varying degrees and with differing intensity, react both behaviorally and affectively to the crisis precipitated by parental divorce, the relevant question becomes: How can the schools help children cope and in what ways can school counselors facilitate the mastery of a child's psychological tasks?

The Theoretical Framework for Helping Children of Divorce

Notable researchers in the field repeatedly identify the issues surrounding effective coping strategies for children of divorce. Wilkinson & Bleck (1977) for example, claim that parental divorce is "not an internal affliction but a developmental crisis to be coped with by all individuals involved" (p. 206). The literature generally supports this theory with slightly different modifications. Felner, Stolberg & Cowan (as cited in Wilkinson & Bleck, 1977) agree that parental divorce for children is a developmental crisis, but go on to claim that given the severity of this crisis, elementary age children cannot effectively cope with this crisis without planned intervention. Divorce is a recognized trauma and those who seek help coping with this trauma seem to adjust best. Social support, from either a network of emotionally supportive and accepting friends or participation in social or professional groups, has been found to buffer stress (Clarke-Stewart, 1989).

Most researchers seem to draw heavily upon the theory of crisis intervention as well as upon developmental coping strategies in loss and mourning as they apply to the loss of divorce (Crosbie-Burnett & Newcomer, 1989; Hammond, 1979; Kaltar, Pickar & Lesowitz, 1984; Kelly & Wallerstein, 1977; Wilkinson & Bleck, 1977). The premise in this theory is perhaps best summarized by Kalter, et al (1984) when he says that "there are pronounced divorce-engendered conflicts and disruptions in social-emotional functioning which are best ameliorated by early intervention" (p. 614). It would seem appropriate, given the time-limited nature of the divorce, that professional intervention is the key to educating children on how to cope effectively with crisis situations.

It is this author's position that the school counselor plays a significant role in initiating appropriate interventions and offering support for children of divorce. This author supports the theory of crisis intervention in helping children of divorce, but suggests in addition to this model: that the child is a part of a larger system and that in order to effect change in the child, the larger system must also be addressed. Wallerstein & Kelly (1977) clearly propose that the divorce represents a time-limited crisis in both the life of the child as well as in the life of the adult. They further claim that a parent's functioning at the time of divorce is often in disequilibrium but that continued parental stability and functioning is crucial to the child's continued development and mastery of the psychological tasks. Often, however, when the disequilibrium precipitated by the divorce precludes effective parental functioning and stability, appropriate interventions as well as the support of other significant adults can aid the child in coping with the divorce trauma.

The School's Role

As previously discussed in this paper, the stress and subsequent adjustment to the divorce is difficult for all aged children. Yet, it is generally agreed that those children aged 9-12 are often more upset and exhibit the potential for greater disruption in school performance than children at any other level. It has clearly been suggested that academic impairment may be one reaction evidenced by children of divorce. This reaction, as well as others, may be due in part to a marked decrease in self-esteem.. The negative impact of divorce on a child's self-concept has been well documented (Kalter, Reimer, Brickman & Chen; Parish & Dostal; Parish, Dostal & Parish; Parish & Taylor; Parish & Wigel; as cited in Burke & Van de Streek, 1989).Burke & Van de Streek also document that low self-esteem seems to be related to academic performance and suggest that the school system help in assuaging these negative effects related to divorce.

Since the school is a significant part of a child's life, and usually the second most stable environment, it seems logical that schools should assist in providing needed support and interventions for children of divorce. The public school setting is increasingly recognized as the natural setting for appropriate interventions for a number of reasons. First, schools provide an excellent opportunity to reach and engage a substantial number of children of divorce. Second, there is a ready-made peer structure in place within the school, which can help to mediate the intervention. Finally, locating the intervention within the familiar context of the school, can begin the process of normalizing the divorce experience for children (Kalter, et al, 1984).

The elementary school counselor can provide assistance and support for the child struggling to resolve the psychological tasks precipitated by the divorce process by concentrating on at least three areas of development: (a) defined communication skills, (b) the need for group work; and (c) the need for consistent assessment (Wallerstein, 1983). At the very least, the school environment can help the child ameliorate the stress of coping with parental divorce. School-based support for children is a priority intervention and can take many forms. This report will outline two primary modalities for school-based intervention: teacher-assisted classroom activities and in-school support groups for children of divorce.

Teacher-assisted classroom activities

Based on data supporting the growing numbers of children of divorce, the odds are high that in any given classroom there will be children coping with the trauma of parental divorce. Teachers might be puzzled about changes observed in these children and can play an important role in assisting in the interventions designed by school counselors. Clarke-Stewart (1989) suggests that at the very least, teachers become well-informed about what to expect from children in these stressful family circumstances. School counselors can assist teachers by helping them know what behaviors to expect from a child during this stressful time. Teachers should know, for example, that children of divorce might become uncharacteristically aggressive, distracted or withdrawn and that academic performance may be adversely affected. Teachers can allow children the time and support needed to bridge their transition and adjustment. Through workshops or informal discussions with teachers, school counselors can be helpful in explaining some of the dynamics of divorce for parents and children. Hammond (1979) summarizes the teacher's role in stating that: "A special word, a touch, or a little kindness from a teacher or counselor may help fill the gap that the child perceives in parental attention" (p.13).

Teachers can also assist in raising the consciousness of other students about what divorce means and about what children whose parents are divorcing might be experiencing. This increased awareness might help forestall the prevailing feeling of isolation often experienced by children of divorce. Hammond (1979)believes that teachers' increased sensitivity to word choice and examples used in family references can bridge the gap for children adjusting to family restructuring. She further suggests that with the use of filmstrips or Bibliotherapy, teachers can provide opportunities for classroom discussions addressing issues of concern for these children. Crosbie-Burnett & Newcomer (1989) suggest in addition to these methods, that a planned guidance activity can be introduced that structure these issues into the classroom (See Appendix A).

Group Intervention

The importance of implementing divorce groups in the elementary schools is vital in reaching the vast numbers of children affected by divorce. School counselors have found increasing success in implementing small groups in the elementary school as a helpful means of providing support for most children (Anderson, Kinney & Gerler, 1987). School intervention programs vary widely from informal "rap" sessions to more formal, structured groups. All, however, have the intent of easing the stress that the child is going through and help to improve self-esteem which is frequently damaged by divorce. Through participation in a group, children learn that they are not alone; that they share similar experiences and feelings particularly through the anger and guilt phases of adjustment. This experience can reassure the child that they are reacting naturally (Tedder, Scherman & Wantz, 1987).

The aim of group intervention is to aid children whose parents have divorced to negotiate more effectively the developmental tasks associated with both divorce and post-divorce experiences. Kalter, et al (1984) details the goals of the small group as follows:

> (1) to normalize the sense of being a child of divorce;
>
> (2) to clarify issues which can be confusing and upsetting;
>
> (3) to provide a safe place for the child to experience and rework the emotionally painful aspects of divorce and post-divorce life;
>
> (4) to develop coping strategies for particularly troubling feelings and family interactions; and
>
> (5) to share with parents the nature of their concern (p. 614).

Groups for children affected by family change and particularly divorce can be structured around a variety of approaches. The literature presents numerous models of structured group therapy designed to assist children in achieving some or all of the above goals and to further ameliorate the stress of the child going through parental divorce. Each model typically includes an introductory or icebreaker activity, a stimulus activity and a closing time. Some children's groups are conducted around a multi-modal approach with activities ranging from health information to discussions about feelings and relationships. Other groups use a set of topics for discussion or age appropriate books (See Appendix B-3) which can lead to examination of common problems and reactions (Anderson, Kinney & Gerler, 1984; Hammond, 1981; Sheridan, Baker & de Lissovoy, 1984; Wilkinson & Bleck, 1977). The Hammond (1981) model seems to provide a comprehensive overview of the elements necessary for a successful children's divorce group and is explained in detail in Appendix C-1. The Wilkinson-Bleck model is detailed in Appendix C-2.

Each model overviewed in this project is typically democratically operated in an open-discussion format with the school counselor providing structure by the introduction of specific topics or activities. Marjorie Bowker (1982) suggests that groups with a focus issue vie less for leadership and seem to settle in to the task at hand more readily. Additionally, this author interviewed two Corvallis area elementary school counselors and gleaned a first hand view of the in-progress structure and effectiveness of children's divorce groups. Both Ann Marek of Adams Elementary School and Linda Fischer of Harding Elementary in Corvallis used adaptations of the models presented in this study. Both counselors were enthusiastic about the effects of short-term group intervention for children of divorce.

Group Format

Members of the children's divorce group are usually selected on a volunteer or referral basis. Frequently, counselors might use a newsletter or flyer to announce the formation of such a group. Because of the loneliness that often accompanies children of divorce, most children are willing to participate in a group (Fischer, 1990 Interview). Some groups were tested with the *Piers-Harris Self Concept Scale (The Way I Feel About Myself)*, the *Walker Problem Behavior Identification Checklist* or the *Hammond Children of Divorce Questionnaire* and grouped accordingly (Burke & Van de Streek, 1989; Hammond, 1979). Interviews or questionnaires are typically used for potential group members to prepare the child for the experience and to inform them of the format and goals of the group. A parental/guardian permission form is probably obtained (Burke & Van de Streek, 1989; Hammond, 1979; Kalter, et al, 1984; Tedder, Scherman & Wantz, 1987).

Groups are generally age-specific and meet between 6-8 times for approximately 45-55 minutes. The sessions are usually structured around a specific theme and include activities specifically designed to allow children to get to know themselves as well as to get to know other children (Bowker, 1982; Burke & Van de Streek, 1989; Green, 1978; Hammond, 1979; Wilkinson & Bleck, 1977). The structure of the groups clearly supports the areas of need for children of divorce as suggested by Wallerstein & Kelly (1976): (a) feelings - understanding and coping with feelings; (b) cognition - understanding what happened and why it happened; and (c) problem-solving - deciding what to do and when to do it.

Setting goals is a primary task for any counselor facilitating a children's divorce group. Some common goals accepted by many experts include the following:

1. Increased personal understanding of the many issues arising when family breakup occurs;

2. Increased ability to identify and express one's own feelings;

3. To facilitate interaction and support among children sharing the experience of divorce;

4. To help children learn how to confront and cope with problems specific to divorce;

5. To provide a comfortable, pleasurable environment for the student;

6. To help children deal with personal relationships, friends and family;

7. To help children change existing negative behavior patterns into more positive ways of acting;

8. To develop an increased sense of positive self-esteem;

9. To learn to listen to others and be sensitive to their needs;

10. To help children clarify, recognize and understand feelings and emotions pertaining to divorce (Bowker, 1982; Green, 1978; Hammond, 1981; Wilkinson & Bleck, 1977).

Additionally, assessment is an important part of the group process. The literature generally suggests that assessment is a follow-up necessary to determine the effects on children coping with divorce (Hammond, 1979; Pellegreno, 1989; Young, 1980). The Appendix in this study provides samples of assessment tools gleaned from this literature.

Divorce groups for children serve to enhance the child's adjustment to this trauma by helping to explore problems and common concerns shared by other children coping with the same crisis. Mahler (as cited in Green, 1978) concludes that groups facilitate a deep self-understanding and self-acceptance which is a significant aspect of the psychological tasks each child of divorce must ultimately master.

Personal Critique

There is no question that the effects of parental divorce on children can be, and often are, staggering. I have attempted to take an objective stance in my view of the literature and to provide a broad overview, not only of the effects of divorce on children, but also on the available techniques suggested for intervention. It was often difficult to maintain my objectivity. I found, however, that the literature recognized the potentially severe impact of divorce on children and that most of the literature approached theory and techniques from a crisis intervention and developmental framework. This approach seemed logical and practical in terms of offering support to children who are struggling to cope with the loss of the family as they knew it. Based on my own personal divorce experience, however, this framework seemed to ignore the larger framework of the child's environment - the family. I feel very strongly that each child is a part of this larger system and that interventions, even school interventions, must in some way address this issue. Some of the literature attempted to identify the need for this systems approach.

Additionally, I found that I was intrigued by the group intervention technique. As a parent of four children who have experienced the shock of parental divorce and in some cases, are still struggling to adjust, I applauded the concept of group sharing. As a counselor who hopes to work with elementary school aged children, I worked overtime in uncovering possible group models and group activities. I was attempting to build my own resource manual.

Although the effectiveness of divorce groups can be measured objectively, I can, at this point in my career, only offer my own subjective measure. Of my four school aged children, only one has participated in a divorce group. This child, a son aged 10, repeatedly enthused about his divorce group. Typically a quiet, studious child, Scott blossomed in the group facilitated by Ann Marek at Adams Elementary and was able to gain perspective and perhaps closure on the divorce experience. He seems to be adjusting well to the divorce as well as the subsequent tomove to a new community. Interestingly, because he is typically quiet and not an overly social child, I was most concerned about his adjustment. Conversely, however, my oldest son (age 12) is an outgoing, athletic individual who has historically made friends easily. However, he has not participated in a divorce group at his middle school and is struggling to adjust to the many changes in his young life. Judging by the results of Scott's participation in the children's divorce group, it would seem that there is a direct connection between the group and adjustment. Ms. Marek, at Adams, is planning a new group for younger aged children of divorce, and I have already requested that my daughters (aged 8 and 6) be considered for inclusion.

As a professional, I see incredible benefits in the use of divorce groups in the elementary school. At the very least, groups are a technique for reaching the growing numbers of children struggling to cope with the trauma of divorce. Yet the benefits seem far greater than a means of mass counseling. The group provides a safe environment for children to discuss issues relevant to the divorce as well as to perhaps assuage that sense of isolation that many children feel. I am encouraged by the literature in this area and plan to incorporate group counseling for elementary aged children in my work as a school counselor.

Conclusion

Divorce seems to be an increasing phenomenon in American culture, affecting millions of children in our nations' schools. Children must adjust to the changes thrust upon them by the divorce process and learn to master certain psychological tasks in addition to their regular tasks of normal development. Sometimes this is an overwhelming burden. Much needs to be done in the continued efforts to help children of divorce become happy, productive children and adults in a society still struggling under the impact of divorce (Hammond, 1979).

Because of the familiarity of the school environment as well as perhaps the stabilizing impact of other adults not struggling with divorce trauma, the school is the logical site for interventions for these children. In order to meet the needs of elementary aged school children adjusting to the sometimes debilitating effects of parental divorce, many schools have instituted short-term interventions in the form of group therapy. The effects of these groups seems to be positive, yet school counselors need to be ever alert to new methods of individual, group and possibly family interventions to meet this growing need of children of divorce.

APPENDICES:

A. Family Change: A Classroom Guidance Activity

B. Group Forms
  - B-1 Parental Permission Form
  - B-2 Student Questionnaire
  - B-3 Bibliography for students

C. Group Models
  - C-1 Hammond's Group Model
  - C-2 Wilkinson & Bleck's Group Model
  - C-3 Values Clarification on Divorce

D. Assessment Forms
  - D-1 Divorce Group Survey
  - D-2 Divorce Group Evaluation

Appendix A

Family Change: A Classroom Guidance Activity

Objectives:

1. To help children of parental divorce by reframing divorce as one form of family change.
2. To suggest various coping strategies for adjusting to change.
3. To provide an opportunity for children to sign up for small group work on divorce-related issues.

Discussion

Types of Families. At least 1 hour should be allowed for the classroom guidance activity. The discussion begins with brainstorming and definitions of the various types of families, including intact/nuclear, single-parent, stepparent, foster, adopted, extended, communal, and any others that the children identify. Students discuss similarities and differences between family types.

Family Change. Counselors explain that all families experience change over time. The counselor and children identify the many situations in which families change developmentally, including births, deaths, separation and divorce, remarriage, and children growing up and leaving home. Counselors may invite children to talk about examples of change in their own families.

Adjustment to Change. Counselors need to explain that when families change, people have to learn how to adjust. Counselors may invite children to talk about how they have adjusted to change in their families or other changes, like changing schools. Then the class discusses the kinds of coping mechanisms that children could try if they are having problems adjusting to change. Common suggestions include the following: (a) *talking* with teachers, parents, friends, counselors, siblings, and other adults; (b) *reading* books about the changes they are experiencing; and (c) *joining* a group with other children with similar experiences.

Introduction of Small Group

Counselors explain that a group for children whose parents have separated or divorced will meet for 8 weeks, once a week, for 1 period, and that the purpose of the group will be to talk about their experiences of living in a divorced family.

Closure

If time allows, the counselor asks the children what they learned from the lesson. Ethically, it is important that the counselor note children who appear distressed by the discussion of family change. If these children do not express interest in the small group, they can be contacted for individual counseling.

Adapted from: Crosbie-Burnett, M., & Newcome, L.L. (1989). A multi-modal intervention for group counseling with children of divorce. Elementary School Guidance & Counseling, 23, (3), 154-164.

APPENDIX B-1

Parental-Permission Form

Dear Parent,

We are planning to offer a series of small group-counseling sessions for fifth and sixth-grade students who are interested in working with other students on the topic of divorce. The time will give the students an opportunity to share feelings, concerns, and coping skills with others whose families are also separated. With the help of a supportive group, we hope the children will learn to accept their own family's situation in a positive way and will be better prepared to handle other life crises.

The six weekly sessions will last approximately 30 to 40 minutes. The group leader, ________________, is the school counselor.

Parent permission is requested for a student to participate in the group. The classroom teachers have been consulted on scheduling and students will not be penalized for missing class time.

If you have any questions, please call the school. Your support is greatly appreciated.

Sincerely,

Guidance Counselor

I give my child ______________________________ permission to participate in the group counseling series.

______________________________ ______________________________

Parent's signature Date

Fischer, L., (1990), Interview on Children's Divorce Groups.

Appendix B-2

STUDENT QUESTIONAIRE

Directions. Below are possible needs of students your age. Read each statement carefully and fill in the appropriate letter in the space provided.

y = yes
n = no
d = don't know

Feelings

_______ 1. I know who I am and what I want.
_______ 2. I often feel angry.
_______ 3. I feel loved
_______ 4. I feel helpless alot
_______ 5. I laugh alot
_______ 6. I am hardly ever sick.
_______ 7. I can tell others how I feel.
_______ 8. I feel that I belong.
_______ 9. I often feel lonely.
_______ 10. I often feel afraid.
_______ 11. I worry alot.
_______ 12. I am usually happy.
_______ 13. I take care of myself.

Home

_______ 14. I get along well with my family.
_______ 15. I wish I had more time with Mom and/or Dad.
_______ 16. I am sure that my parents love me.
_______ 17. I help alot at home.
_______ 18. People listen to me when I have a problem.
_______ 19. My parents do not live together.
_______ 20. My parents fight alot.
_______ 21. I would like to see my family hug more.

Educational (I need to:)

_______ 22. do well in school
_______ 23. keep my mind on school work.
_______ 24. learn how to avoid trouble at school

_______25. get along with my teachers.
_______26. be more proud of the work I do in school.
_______27. be able to work and ask questions in class.
_______28. know how to study better.
_______29. be a better listener.
_______30. know how my school work can help me.
_______31. know what it is like in the next grade.

Social (I need to:)
_______32. know how to make more friends.
_______33. learn how to keep my friends.
_______34. know what to do when things go wrong.
_______35. have at least one good friend.
_______36. know how to solve problems.
_______37. be able to stick up for myself in a group.
_______38. not worry so much about what other people think.
_______39. know how to help my friends when they feel bad.
_______40. learn how to help my friends solve their problems.
_______41. know how to say what I mean.
_______42. learn how to make decisions more easily.

Comments:

Fischer, L., & Marek, A., 1990. Interview on children's divorce groups.

Appendix C-1

Group Counseling for Children of Divorce: A Model

Session 1. The group leader in this session introduced herself and discussed the purpose of the group. The children were then asked to establish rules for the group. These rules were written on a blackboard and reviewed. The final part of the session had students introduce themselves and discuss their background.

Session 2. A filmstrip and cassette from Hammond's program were used to aid the students in understanding why people sometimes divorce. A game called "knots" was then played, in which each child stood in a circle and grabbed the hand of a child across from him or her. The children then were asked to form a new circle without letting go of the hand of the other child.

Session 3. A series of four pictures was shown to the children. Picture 1 depicted a mother crying and a father leaving, with a child in the middle. The second picture showed the mother and father each pulling on an arm of a child. the third picture showed the mother in love with another person and a child watching. The final picture showed the mother and child together at a school parents' night. All the other children in the picture had both the mother and father with them. The children were asked what was happening in each of the pictures. They were then given an opportunity to discuss the pictures.

Session 4. The group leader asked the children to draw the homes their families lived in. The children expressed their feelings and discussed the idea that people can live in different homes and still be a family. The children were then asked to draw a family coat of arms, which they divided into five areas. These areas were subsequently filled with drawings of their families having a good time, an unpleasant time, a picture showing why their parents got divorced, and what they would like their families to be doing next year. After drawing these pictures, the children wrote a three-word description of their families in the bottom section.

Session 5. In this session a story about a young boy whose father moved away from home after a fight with his mother was read to the group. The boy in the story feels he is responsible and thinks that if he would behave better, his parents would reunite. This story was then discussed with the children.

Session 6. The children were shown a cartoon in which they learned that a person can make changes only in himself or herself, not in others. The second part of the session aided the children in clarifying their own preferences. The children also discussed being true to oneself and not conforming to peer pressure.

Session 7. A handout titled "Empathetic Assertion" was given to each child to fill out. This handout had the child complete such sentences as "I feel angry when my mother ______." After the questionnaire was completed, the children were then encouraged to practice what they had learned, and a challenge sheet was given to each child. This challenge sheet asked each child to list a specific problem at home. The group then brainstormed ideas for the child to use at home to deal with his or her problem.

Session 8. During the final session, the children reviewed what they had learned during the 8 weeks. The children were encouraged to continue to support each other in the future.

Adapted from Hammond's (1981) *Group Counseling for Children of Divorce: A Guide for the Elementary School* (as cited in Burke & Van de Streek, 1989).

APPENDIX C-2

THE CHILDREN'S DIVORCE GROUP

Group Activities

Session I: Introduction and Ground Rules

Naming each other: Students (as well as the counselor) are asked to try to name the other members.

Discussion rules:

1. Take turns speaking - only one at a time
2. Raise your hand if you want to talk
3. Anything said is OK
4. Think about what the others are saying
5. Things said here are private for the group

Sharing a secret. Share things about selves that no one else knows. The counselor usually begins the sharing by giving a personal example of a secret. Often the children are encouraged to write their secrets which the counselor then collects and reads to the group, pointing out similarities and differences.

Session II: Nondivorce-Related Self-Disclosure

An animal like you. The counselor says, "Last time we shared secrets and we started to become better acquainted with each other. Today we are going to do something a little different. I'm going to hand out a piece of colored paper; I would like you to draw a picture on it of one animal that you feel is most like you. For example, I would draw a lion become sometimes I growl at people if they get me mad. I knew somebody who drew a bear because he was very lazy and like to sleep a lot. Someone else drew a mouse because he like to eat a lot of cheese. Some others drew deer because they were as gentle as little deer. Remember, try to think of an animal that is like you. After you draw your animal, cut it out and write your name on the front of it." When everyone is finished, the counselor encourages group members to share their animals, giving reasons for their selections. Similarities and differences in choices are discuss.

Pleasant and unpleasant feeling words. The counselor says, "As people get to know each other better it is important that they recognize and share their feelings. Now we are going to list as many feeling words as we can think of. We'll make two lists because some feelings can be pleasant and others can be unpleasant. Let's list as many as we can." For example, What kinds of feelings do you have on your birthday? What kinds of feelings do you have when you are playing a game and losing?

Session III: Filmstrip on Divorce and Discussion.

Filmstrip and discussion. The counselor introduces a filmstrip called "Understanding Changes in the Family: Not Together Anymore" (Guidance Associates 1973), which presents many of the feelings children have that are associated with their parents' divorce. Afterwards, the counselor encourages the members to identify and discuss the various feelings exhibited by the characters in the filmstrip. The counselor leads the members to disclose the feeling-behavior-consequence sequence by asking "What did that feeling make you do?" and "What happened as a result of what you did?"

Session IV: Divorce-Related Self-Disclosure

Personal Shield. The counselor says, "Last time we discussed many feelings associated with divorce. Today we are going to continue dealing with the feelings and behaviors surrounding divorce, through pictures. Each of the shields I'm handing out contain four separate parts. I will describe what I would like you to draw for each part." The counselor then gives the following directions:

1. Draw a picture about a good time you had with your family.
2. Draw a picture about an unpleasant time you had with your family.
3. Draw a picture that shows why you think your parents got a divorce.
4. Draw a picture of something you would like to see happening to your family in the next year.

When everyone is finished the counselor asks the group members to place their shields in front of them for all to see. A volunteer is then asked to share and describe one or more of the drawings to the others. The counselor reflects feelings that have surfaced as a result of the sharing. Similarities and differences are noted when appropriate.

Session V: Role Playing the Problems of Divorce.

Brainstorming problems. The counselor says, "During the last few weeks we have discussed many of the feelings and behaviors associated with families that are not together anymore. Now we are going to talk about some of the problems created by the divorce. Let's make a list of as many problems as we can think of. Don't be afraid to mention any problem that comes to mind."

Ranking problems. The counselor continues: "Let's try to decide the two or three problems most important to the group. The group then votes on the problem situations that are most important to them.

Role Playing problems. The counselor then structures the role playing of important situations by asking the members which characters are needed and by recruiting volunteers to play these roles. The counselor can give further direction by describing an appropriate setting and suggesting beginning dialogue. Other group members may assist the characters in dialogue or action. Each role play might last between 3 and 5 minutes, after which the counselor leads a discussion focusing on the important feelings and behaviors of each character. The consequences of the character's action can be discussed.

Session VI: Puppet Play of Coping Behaviors

Puppet Plays. The counselor says, "Last time we listed some problem situations that occur when families separate. We had a chance to role play a few of these and discuss the feelings and behavior of each play. Today we will use puppets to dramatize any of the problem situations discussed last time or any new ones you may wish to add. Who would like to be the director of our first play? The-director will make up a story and tell the other characters who they are and what they are to do. The director can pick any member from the group to help." After the puppet play, the counselor leads a group discussion of the feelings, behaviors, and consequences of the characters in the play. The counselor then asks the members to suggest alternate ways of dealing with the enacted problem. Once these are clarified, the puppet play can be reenacted using the new alternatives. As before, the discussion centers on feelings, behaviors and consequences. Other puppet plays can be created if time allows.

Session VII: Positive Aspects of Divorce.

Divorce collage. The counselor says, "For the past few weeks we have been talking about the problems and unpleasant feelings surrounding divorce. today I'd like for us to think about those things that have turned out to be pleasant or positive as a result of your parents separating. Some children have said that is has been easier to have their friends visit because now they don't have to worry about being embarrassed by their parents fighting. Others have said that after the separation they have gotten to know one of their parents a lot better. Let's make a collage of some pleasant situations that can come about because of divorce. Look through these magazines and cut out pictures that might stand for those situations. You may also draw pictures to represent situations you cannot find in the magazines." When the children are through, the counselor encourages them to share their personal collages. The counselor reflects, clarifies, and points out similarities and differences mentioned by group members. For example, "Both John and Carol have selected pictures that show a child and parent having a nice time. They say that since the divorce their parents have had more time to spend with them doing fun things. Has anyone ever shared these ideas and feelings with one or both of your parents? Do you feel that it might be important for them to hear these ideas and feelings? How do you feel about sharing your collage with them? What are some other ways we can tell them these pleasant things?

Session VIII: Summary and Ending

Positive feedback. The counselor says, "Often we want to tell others how we feel about them, but sometimes we find it hard to put our feelings into words. Telling others how you feel about what they are doing or what they have done is called feedback. I would like a volunteer to sit in the 'feedback chair.' Now I would like the rest of the group to give this person some positive feedback or relate only your pleasant thoughts. I know it is easy to say negative or mean things about other people. Even though it is is harder, saying the nice things makes us all feel so much better. For example, you could simply say you like the way someone wears his or her hair or how someone has helped you with some schoolwork or been really kind when you were upset. Try to be specific about what that person has done or describe some feature that you find positive. You can also tell that person directly how that feature or behavior has made you feel. Remember, be specific about what you think is a positive feature or behavior and tell how it makes you feel. Try to talk directly to the person, using his or her name instead of talking about him or her to the others." Each child who wishes to volunteer for the feedback chair is given the opportunity to do so.

"I learned" statements. Each member is asked to relate the things they have learned in the group by using the "I learned that" format. The counselor summarizes and leads a discussion on ending the group.

Wilkinson, G.S. & Bleck, R.T., (1977). Children's divorce groups. Elementary School Guidance & Counseling, 11, 205-213.

APPENDIX C-3

VALUES CLARIFICATION ON DIVORCE FOR ELEMENTARY SCHOOL CHILDREN

If you agree with a sentence mark an "A". If you disagree with a sentence, mark a "D".

_______ Parents should not get a divorce until their children are grown-up.

_______ Sometimes when parents divorce it is the children's fault.

_______ Children from divorced families can be just as happy as children whose parents are married.

_______ If children promised their divorced parents that they would be very good they might be able to get them to come back together.

_______ It is better for parents to divorce than to fight every day.

_______ A parent who does not live with a child can still love him/her very much.

_______ Kids whose parents are divorced get into more trouble at school.

_______ It is better not to tell anyone if your parents divorce.

_______ Step-parents are usually mean to children.

_______ It may be good for the children to live half of the time with their Dad and half of the time with their Mom.

_______ It is always better for children to live with their mother.

_______ When parents divorce it is a very difficult time for all families.

_______ Once people marry they should never get a divorce.

(Adapted from: Hammond, J., (1981). Group counseling for children of divorce: A guide for elementary schools. Ann Arbor, MI: Cranbrook Publishing Company.)

Appendix D-1

DIVORCE GROUP SURVEY

Parents:

Your child has participated in a "Divorce Group" at ________________
School. With your approval, I'd like to learn more about your feelings, thoughts and observations regarding the group. I appreciate your time in completing this survey.

Sincerely,

Counselor

1. How did you first learn about the Divorce Group
   - ______Letter from counselor
   - ______From a friend, neighbor

2. What were your reasons for having your child participate; what benefits did you foresee your child deriving from the group?

Were those expectations met?

3. Have you noticed any of the following positive changes in your child?
   - -more verbal about feelings
   - -more accepting of the divorce
   - -less acting out - less anger
   - -more accepting of a step-parent (if applicable)
   - -other ____________________

4. What would you like to see changed, or what would you like included that was not?

5. Would you recommend the group experience to another parent or child?

   ________yes   ________No

Please use the reverse side for further comment.

(Fischer, L., 1990, Interview about children's divorce groups at Harding Elementary School)..

APPENDIX D-2

DIVORCE GROUP EVALUATION

Date Group Started ____________________
Date Group Ended ____________________
Group Name ____________________

Now that group is over, your feelings and attitudes may have changed. Please respond to the following statements by describing how you feel in relation to the group and its members.

1. I learned:

2. I feel:

3. I am:

4. Divorce makes life different by:

5. I think:

6. A good thing that has happened is:

7. Divorce is:

8. I've changed by:

9. What I liked best about the group was:

10. What I liked least about the group was:

11. If I could change something about the group, I would change:

Additional comments

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THE DROPOUT AND THE COUNSELOR:
Hope for the Future

by

Vicki Thomas
Oregon State University
Department of Counseling

Twenty-five percent of one of our nation's most valuable resources is going to waste. Youth are the future of America and yet one in four will dropout from school before receiving a diploma (Catterall, 1987). The reasons for leaving school are complex, yet the use of the word dropout might imply simplicity (Gawda & Griggs, 1985; Kushman & Kinney, 1989). Phi Delta Kappa's Center for Evaluation (cited in Mann. D., 1986) concluded:

> *We simply cannot agree what a dropout is. In some districts death, marriage, taking a job, entering the armed forces, entering college early, being expelled or jailed, going to a deaf school, business school, or vocational school causes one to be considered a dropout In another district, none of these acts would be considered. . . . (p. 9)*

Fine and Rosenberg (1983) call the term dropout "colloquial" and use it, "with the understanding that many of these youth have been thrown out, pushed out, or never been allowed into the mainstream of secondary education" (p. 258). "Dropping out is not an isolated event, but a culmination of conditions and actions experienced long before the decision. . . . the seeds may be developed as early as first grade" (Howard, 1978, p. 223). "Dropout-ism" is an enormous problem of our nation's schools. The Bureau of Labor Statistics (cited in Bialo & Sivin, 1989) reports:

> There were over four million dropouts between the ages of 16 & 24 in 1985. . . . Estimates of our nation's overall dropout rate range between 14 and 25%. . . . dropouts are less likely to seek work than graduates. . . . opportunities are limited. . . . dropouts earn about one third less than high school graduates. (p. 35)

"Dropout-ism" also has serious implications on society as a whole (Bearden, Spencer & Moracco, 1989; Beck & Mira, 1980; Bialo & Sivin, 1989; Fine & Rosenberg, 1983; Kushman & Kinney, 1989). "Caring for low birthweight babies born to mothers on welfare who are high school dropouts costs $188 million per year. . . . the nation spends $20 billion annually on prisons" (Pennar, 1988, p. 123). The higher the dropout rate, the greater the prison populations and vice versa. For example, "Minnesota has the best graduation rate in the country (90.6 percent) and ranks 49th in prisoners per 100,000 population" ("Get Good Start," 1990, p. 10). Fewer dropouts mean less arrests. The Stanford School of Education Study (cited in Youth At Risk Report, 1989) states, "Attainment of a high school diploma reduces the probability of arrest by more than 90%" (p. 16).

The overall implications for the students who leave school without a diploma are grim. It seems that the school dropout is destined to become the burden of society. The *purpose of this article is to give the reader a better understanding of who the dropout is and to suggest ways in which the counselor might intervene while the student is still in school.*

WHO IS MOST LIKELY TO BE A DROPOUT?

Research has shown that the "typical" dropout is more likely to be male than female and is apt to come from a large urban or small rural school district (Bearden et al. 1989; Beck & Mira, 1980; Kaplan & Luck, 1977; Kushman & Kinney, 1989). Where boys leave school to seek paid employment, girls most often leave to have a baby or to get married; substance abuse might also be an issue (Bialo & Sivin, 1989; Druian & Butler, 1989; Fine & Rosenberg, 1980; Human Resources Division, 1987; Kushman & Kinney, 1989). A greater percentage of dropouts belong to racial or ethnic minorities, with the rate being highest among Hispanic youth (Fine & Rosenberg, 1983; Human Resources Division 1987; Kaplan & Luck, 1977; Pennar, 1988). A higher number of dropouts come from blue-collar or lower white-collar homes and often from single-parent families where work ethics, or survival is the "norm" (Bachman, Green & Wirtinen, 1972; Pennar, 1988). Frequently the parent/parents of the dropout did not finish high school themselves and do not provide much encouragement toward educational goals (Cervantes' study (cited in Beck, 1980); Druian & Butler, 1989). Emotionally, behaviorally, and cognitively, who are these young people? Conrath (1986) describes them as "discouraged and defeated learners":

> 1. They are low in self confidence, have a deeply held sense of personal impotency, helplessness, and lack of self-worth.
> 2. They are avoiders. They avoid school because it is demanding and/or threatening. . . . They avoid contact and confrontation with other students and adults, for they are not confident of themselves. They avoid classes because they are "behind" . . . . Avoidance of adults and school begins in very early grades.
> 3. They are distrustful of adults and adult institutions. Adults in their life often have been unfair, unresponsive, or even abusive --mentally, intellectually, and/or physically.
> 4. They have a limited notion of the future. They are very responsive to short-run measurable goals. . . .
> 5. They usually lack adequate reading, writing, and math skills and have come to see themselves often as "dumb" rather than unskilled. Many adults see them that way too. Dumbness, goes the reasoning, cannot be cured so

adults give up on them and the kids give up on themselves.

6. *In fragile homes, their parents often suffer similar characteristics: low skilled, low self-confidence, distrustful of institutions, avoidance, suspicious of the future.*
7. *Discouraged learners often have, by textbook definition, adequate peer relationships. Some are powerfully lonely. . . . Adults usually do not approve of the peer relationships. . . . self-confidence will begin to grow with success in learning and skill development; not through critiquing their friends.*
8. *They are impatient with routine, long-time sitting and listening, and classrooms with little variety . . . . Because of this, and their low skills, discouraged learners are often seen as disruptive when they demonstrate their impatience, or when they ask the intelligent question "Why do we have to do this?"*
9. *Discouraged learners often come from the category of learning preference identified as "practical". . . . they are good at working out applications of what is being taught if that is allowed and encouraged. They learn well through their own private experience and can talk about that better than write about it.*

> 10. Most significantly, discouraged learners do not see a relationship between effort and achievement. . . . They are "externalizers" -- people who see the world as happening to them and one over which they have little control of events, especially failures and successes. (pp. 5-7)

THE ROLE OF THE COUNSELOR

The counselor can become a catalyst in meeting the needs of the potential dropout. The counselor can begin to create an environment to encourage this disgruntled learner. Various techniques which help to create an encouraging environment will be discussed in the next section as the counselor works with students, works with data, and works with staff.

Works With Students

Peer Support Program

The counselor can be instrumental in establishing and facilitating peer support/tutor programs. Such is the case at Dale Ickes Junior High School in Milwaukie, Oregon. The purpose of the "Student Specialist Program" is (Meechan, 1989):

> To make it socially acceptable to help and support one another, particularly those who have any kind of social or academic need. . . . they meet the the same peer every day.

> *same period. . . . Because of the attitude of caring and sensitivity of Student Specialists, these peers are naturally drawn to them for support for whatever problems they have. Student specialists will receive training throughout the year. . . practical experience in the peer's classroom . . . . every two weeks they meet as a group to discuss how things are going . . . have some type of class or lecture instruction . . . . might role play a situation they're having trouble with. . . . Student Specialists strive to model: good eye contact -- look at person you're helping; maintain a genuine interest in his/her response; say "hi" when you see someone in the hall with whom you've been working; be patient; remind your friends (if necessary) not to be fast to judge someone else; and, arrive promptly and leave at the end of the tutor period. (pp. 1-6)*

When asked about theory, Carol Meechan, counselor-adviser of Ickes' "Student Specialist Program" replied, "It's a lot like trial and error. Some of it is practical . . . a chance for the students to learn how to do something . . . like talk to a peer regarding inappropriate attitude or how to talk to a teacher regarding a problem" (Interview, 1990). These techniques of problem solving, modeling, role playing and building self-esteem seem to be based on reality, cognitive and behavioral theory. In reading through the handouts that describe the program, a sense of *professional commitment and accountability is present. The job of training and preparing "Student Specialists" seems a high priority for Carol Meechan and her staff. This is evidenced by the thorough manner in which each phase of the program (selection, training, implementation, and communication) is explained. It appears that "Student Specialists" have been treated in the same nurturing manner in which they are then encouraged to treat others. A modeling of the techniques (caring, sensitivity, active listening and use of positive regard) begins with the counselors, projects to the "Student Specialists", and then extends to those "who have any kind of social or academic need" (pg. 1). A special bond of friendship and support between peers will be only one of the outcomes from this program at Ickes' Junior High.*

Works With Students

Individual Educational Programs (IEP)

Counselors can be a resource for students with IEP's and for the staff that works with them. A specific program of this nature is in place at Clackamas High School, Milwaukie, Oregon. Specialist John Geller (1989) provided the following information on "S.A.I.L. -- Student Advocates Inspire Learning":

> *Purpose of Program -- Provide case management services for high risk special education students with the goal of lowering the dropout rate of this target population.*

Students Served -- All S.A.I.L. students must be an IEP. All students are certified as emotionally handicapped and/or learning disabled.

Services Provided --

1. S.A.I.L. Groups -- Students meet every day in small group sessions. Curriculum covered in groups includes survival skills, drug abuse prevention, problem solving/decision making skills, assertiveness training, social skills, taking responsibility training, communication skills, goal setting/scoring, and increasing positive self-esteem. Group activities also include basic rap sessions, study days, and game days. All S.A.I.L. students are eligible for receiving school credit based on performance.
2. One to One Support -- Students receive private counseling/crisis intervention from S.A.I.L. staff.
3. Teacher Contact -- S.A.I.L. staff stays in contact with students' teachers to monitor progress and provide support when/if needed.
4. Agency Contact -- S.A.I.L. staff stays in contact with other agencies working with students to monitor progress an coordinate treatment plans.
5. Parent Contact -- S.A.I.L. staff stays in contact with parents to monitor progress in home environment and share information concerning school performance.

6. *Administration Contact -- Effective relationships between students and administrators promotes learning and student retention.*
7. *School Psychologist Support -- Psychologist participates as a group member once a week and provides clinical supervision for SA.I.L. staff.*

Related Issues

1. *Endorsement of a therapeutic relationship.*
2. *Utilization of basic principles of classroom management.*
3. *Reality therapy/choices and consequences positive and negative.*
4. *On-going feedback regarding student academic performance.*
5. *Assistance in completion of classroom routines and tasks, i.e. learning styles, homework, tests, tutoring, detention.*
6. *Consultation regarding assessment and management of behavioral problems.*
7. *Students are required to set academic and personal goals in writing which are reviewed in detail with students and scored and discussed in groups every week. (pp. 1-2)*

This is one of the few programs that addresses theory and "endorsement of a therapeutic relationship." John Geller acknowledges a base of reality therapy in the "S.A.I.L." program at

Clackamas High School. It also seems that this program is based on cognitive/behavioral theory as well. It is important to address one section of the "S.A.I.L." handout entitled "Memorandum": dated 12/12/89; Subject: Provisions of S.A.I.L. Program Services to Students/Families for One Year Period or Longer:

> Of ten items listed, eight directly speak to the importance that the student be in class for at least one year; that it requires time 'to impact'. . . . It may take a year or quite longer to build trust and relationships. . . . It takes more than one year 'to impact' for those things. Students are 'clearly told'. . . . students are 'made aware'. . . . 'impact' behavioral/emotional problems. . . . 'Enforce' natural consequences. This memorandum discusses self-esteem with words. . . . A feeling of 'power' which is lacking in the lives of distrubed adolescents. . . . gives them a feeling of 'power' in their unity. . . . gives students the 'power' of choice. . . . the feeling of 'power' often motivates them. . . . (p. 4-5)

If counselors spend one year in S.A.I.L. I wonder if they, too, will be "impacted" with power and self-esteem or merely "impacted"? My sense is trust is built by "impacting" and that power = self-esteem. Is this an indicator of the program's theoretical base? Some questions need to be posed. Does reality therapy allow for nurturing? Is it about POWER? Does the end always justify the means? One must wonder what success is based on in this classroom; how the therapeutic relationship is defined; and, who has the most power? Reading over the pages causes one to feel quite POWERLESS. Ultimately, one must wonder how the "S.A.I.L." program "Impacts" the potential dropout?

Works With Data

To help get a clearer reading on the academic picture of the potential dropout, the counselor needs to be a data collector. "Keeping track of most recent progress reports, attendance records, overall G.P.A.'s (lower than 2.0) and total credits -- the biggest red flag of all (fewer than 4 for a freshman; less than 15 for a sophomore) are part of what Pat Warnell, MST does as the "Options in Education" specialist at Corvallis High School, Corvallis, Oregon (Warnell, P., 1990). Similar data is also received about incoming freshmen from middle school counselors. This information is then shared with high school counselors and teachers. If the recommendation is to focus on study skills, one-on-one tutoring and/or better organizational skills, the student will be scheduled into one of Warnell's PAT (Personal Assistance Time) classes. This program reaches 100-130 students per year. In addition to the Option's Specialist, an assistant teacher and several Oregon State University practicum/intern students are available to meet the individual needs of Warnell's students She observes (Warnell, 1990):

> . . . that "her kids" do not operate at optimal levels; that they don't feel good about themselves and so they have shut down. They need to be encouraged to see beyond what they're doing at the moment. I try to get inside their world. It's not productive to be judgmental; their life experiences have not been positive. . . . I really like kids! (Interview)

As Pat Warnell interacts with students to review for a test, to understand a math problem, to organize their binder, or to listen to their hurts, she also affirms their worth as individuals. Her techniques of showing empathy, acceptance and positive regard are a critical factor in the success of the "PAT" program at Corvallis High School. While she indicates she "does not follow any one theory" (Interview, 1990), my guess is that Pat Warnell believes in the natural goodness of the individual, one of the constructs of humanism. She also shared an interesting observation (Warnell, 1990):

> As I look back on how this program has grown over the past 3 years and that some of the summer school kids are here, too, there's this feeling of being a kind of a family. . . that as the kids ineract with each other, and some even come in here who aren't scheduled, there is a bonding. . . they're building a support system. . . a sense of security and

> *belonging. They leave their bikes here; they bring books in; they sometimes check with me before they leave. . . . It's a combination of knowing a lot about kids, a lot about teaching and a part of it is sensory. . . like an orchestra . . . it just develops . . . it just begins to grow. (Interview)*

I sense students who come into her class will leave with much more than improved academic skills!

Works With Staff

Counselors can organize and help guide school staff that want to do something extra for their students. Milwaukie High School in Milwaukie, Oregon, has undertaken the project "CAKE" (Caring About Kids Effectively) for the 1989-1990 school year. This is a volunteer mentor program made up of staff, cooks, administrators, secretaries, and selected "Natural Helper" students. The goal is to show care or concern for "special young people who have had more than the average amount of problems adjusting to our school environment or their own home environment" (Johnson, 1989, p.1).

Students have been referred to the group by junior high school teachers, counselors or administrators. Milwaukie's staff has also referred students. Ideally, there will be a positive bond established between mentor and "kid". General guidelines for "CAKE" include (Johnson, 1989):

1. *Keep it simple for the first year.*
   - a. *Try and keep activities inside this building (outside activities need parental permission).*
   - b. *Suggested activities: (These are suggestions only!)*
     - 1) *Birthday Cards*
     - 2) *Periodic visit or communication with teachers or counselors regarding progress in class. You can send positive notes to the student when he or she is doing well, and encourage them when they are not.*
     - 3) *Communicate with your student during your prep or whenever. . . .*
     - 4) *Ask for an attendance office printout. After an extended absence, call your student and let him or her know they're missed. Remember, we're not truant officers.*
     - 5) *Just listen, show you care, help them get involved in activities, etc. Don't get into heavy counseling. Be a friend, and adult they can look up to.*
   - c. *See your student as frequently as you wish (once a week -- more or less -- based on the student, your relationship, needs.etc.).*
2. *See the student's counselor if:*

   a. *You have questions on confidentiality (we'll inservice all staff in the fall on this question).*
   b. *You have a difficult situation.*
   c. *You need more information about the student.*
   d. *You want to see progress reports or grades, etc.*
   e. *You need advice on a tactic.*
   f. *You hear anything life-threatening.*
   g. *You want to be kept informed about any major discipline referrals.*
   h. *You have questions on any agency referral (we'll also inservice this area in the fall).*
3. *Mentors will probably meet voluntarily once a month to share ideas, problem solve, give each other reinforcement, hear speakers related to the area of "at risk" students, give input as to how things are or aren't working, etc.*
4. *If you absolutely cannot work with a student, then:*
   a. *See a Senate member and voice your concern.*
   b. *Ask that another student be assigned.*
   c. *Trade a student with another adult (let the Senate know if this is done . . . record keeping!).*
5. *The Senate will let you know if your student has moved or dropped.*
6. *The Faculty Senate will provide an inservice this fall*

regarding:

a. Confidentiality -- legalities, etc.
b. Parental contact -- permission slips, etc.
c. Agency referrals - student requests or yours.
d. Makeup of an "at risk" student.
e. Dealing with an "at risk" student.
f. Things to say -- possible role playing.
g. Tracking the "at risk" student.
h. Whatever else that we need.

7. Don't be discouraged if your youngster isn't doing well. The fact is, some will not, especially if their problems are severe or chronic. Please share your feelings and frustrations with another mentor or a counselor. (We're all in this together! A first try! Remember, we're light years ahead of anything we've done in the past!)

Confidentially

In order to develop trust, you must respect information shared by the student as confidential! (In a recent court case, a student in Oregon successfully sued a teacher for "spreading rumors" about that student.) If you have a concern about your student, see his/her counselor.

Life Threatening Situation

If the confidential information given to you by your student is possibly "life threatening", you must report this to a *counselor or administrator. This includes suicide, pregnancy, running away, fight, drug/alcohol abuse and physical abuse.*

Parent Permission for Leaving Campus

Parents must sign a note giving you permission to take their son/daughter to off campus. Phone approval will not hold up in the court system. You could get a "blanket" permission signed by the parent so that you have this in your files. All you need to do is let the parent know where and when you will be leaving and returning to school. (pp. 6-8)

Sue Johnson, coordinating counselor, mentions no specific theory in her discussion of "CAKE". The techniques aim at making the student feel special; to have a mentor connect with them on an individual caring level. The manner in which this program is presented seems very warm and inviting. The message that the counselor is there if anyone should have any doubts or questions, permeates the entire handout. The counselor's willingness to be available creates a safe and inviting environment for the potential mentor to risk trying something new. The techniques that encourage this "safe" atmosphere for the mentor will hopefully do the same for the potential dropout. A strong sense of professionalism and accountability exsists in how issues of confidentiality, life threatening situations, and *rights of parents are addressed. My guess is that the majority of Milwaukie High School has volunteered to become mentors for the "CAKE" program and that their dropout rate will decrease, too!*

PERSONAL REACTIONS TO COUNSELING TECHNIQUES AND THEORY

I feel I have addressed specific techniques and theories in each of the previous sections of the "Role of the Counselor." Generally speaking, I am amazed at how many professionals "out there" seem unable to differentiate between theory and techniques. The pervailing message in working with dropouts is to "keep the best interest of the individual student at heart." The best solutions are to show positive regard; to be empathetic; to be congruent; to ultimately build self-esteem. And yet, I get a sense that professionals are unable to recognize when these characteristics are techniques and when they are theoretical constructs. Or perhaps they can differentiate but are unable to communicate. Whichever is true, the professionals I experienced did not seem to have the apparent understanding that while techniques may vary, counseling theory, which is based on a person's NOP, remains constant.

Another observation was that there seems to be considerable overlapping of reality, behavioral and cognitive theories. People I experienced often referred to the theories collectively. Words like "practical" and "experiential" were also used interchangeably with reality and/or behavioral theories. This lack of clarification often resulted in confusion on my part.

CONCLUSION

The problem of the school dropout is indeed a multifaceted issue. This article has been about identifying and understanding characteristics of the potential dropout and identifying and explaining interventions to mitigate the situation. I believe there are two elements to the solution of the dropout dilemma.

The first consideration is the potential dropout student. I agree with Bearden, Spencer & Moracco (1989), on the importance to not discount the history the potential dropout brings to school. However, I veiw history as only one segment of the total individual. I believe there is the need to accept the potential dropout where he/she is at (from his/her perception of EVERYTHING and how all that data manifests itself). I view this whole presenting package as the starting point for the dropout.

The second consideration is "who" will be doing the intervening? I see the school counselor as the most natural resource to initially intervene in the school setting. I have a visual picture of a wheel. The counselor is the main hub with the spokes being professional staff, nonprofessional staff, family members, students, support groups, curriculum options, businesses, government agencies, local organizations, juvenile authorities and alternate schools. The myriad of options and programs is endless. It is crucial that the counselor be aware of all the possible options to best connect with the individual needs of the potential dropout.

The school counselor usually has the initial contact with the potential dropout. Then, as I've described, this student might be directed in another direction, to a program to best meet his/her individual needs. Who will then be the person to intervene and have the majority of contact with the potential dropout? My research and personal experience have validated what I believe to be the most critical piece of the dropout puzzle -- the person doing this intervention. I believe that the likelihood for an individual to suceed in this intervention phase is directly proportional to their level of desire and commitment to the entire dropout process. I believe one needs to be in a mindset of "it is my choice to work with this student because I want to" -- not because it's my job; not because it will give me something positive to talk about at the vice principal's meeting; not because it will make me look good at the Governor's Convention; and, certainly *not because I "should". If and when we as administrators, teachers, counselors, parents, staff, friends decide we want to be the potential dropout's advocate -- THEN I believe we're ready to intervene on their behalf.*

If one is to be an advocate of the potential dropout then I believe these are the theories and techniques upon which that decision is based:

1. *A philosophy or theory: based on unconditional positive regard, empathy, and congruence; that allows for the bridging of techniques that promote the elimination of maladaptive behavior/thinking; that allows for the bridging of techniques that promote the ability to learn and the ability to change.*
2. *A philosophy or theory: based on eliminating maladaptive behaviors/thinking; that believes in the ability to learn and the ability to change; that incorporates techniques of unconditional positive regard, empathy and congruence.*
3. *A philosophy or theory: based on the circularity of casuality and not linear causality; that is based on separating the part from the whole, the person from the problem -- that empowers each potential dropout to explore their part of the total problem; that allows each society norm, government agency, school district, school, family, administrator, parent, employer, counselor, teacher, peer -- to explore their part in*

the individual dropout's problem. In other words, implementation of a systems theory approach is warranted.

4. *A philosophy or theory that allows for the bridging of techniques that promote circularity of casuality and other constructs of systems theory.*
5. *The allusive, intangible, and ever important ingredient of "the right chemistry", the "something magic"; the sense of something finally working.*

Counselors, educators, and administrators cannot control the starting point of the potential dropout. Whoever does the intervention must have the mindset of being the dropout's advocate. Various theories and techniques can promote positive change in the potential dropout. The school counselor can serve as the director of the most important challenge facing our schools -- to prepare EVERY student to be a functional member of society.

THERE IS HOPE!

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BEREAVEMENT OF ADOLESCENTS FOLLOWING THE SUICIDE OF A FRIEND

by

Gail R. Winden
Oregon State University
Department of Counseling

Abstract

The number of adolescents committing suicide is staggering, but concern is now being directed toward those adolescents grieving for a deceased friend. This paper will examine suicide, placing a focus on how adolescent friends of the suicide victim cope with that death. Suggestions will be offered to help with the grief process using Rogers client-centered approach, Gestalt approach, and existential group therapy.

Suicidal Statistics

In 1985 suicide ranked second as the leading cause of death for young people between the ages of 15 and 24. Adolescent suicide has increased by 237% between 1960-1980. It is believed one million people each year attempt suicide and that 25,000 of those succeed (Balk, 1983). These figures are now prompting a concern by counselors who must deal with the bereaved friends of the young people committing these suicides.

Although little attention has been given to bereavement in adolescents, the concern is now being raised and the issue discussed and explored. It is believed that six friends per death will be affected (Balk, 1983). Failure to grieve by the adolescent can lead to a suicide attempt later on (Richman, 1986).

Prior to 1977, the leading cause of death among adolescents as a result of suicide was ranked third after accidents and homicides. Today suicide has by-passed homicides and is the second leading cause of death (Epstein, 1974). According to the World Health Organization (1968), a suicide act is defined as a self-inflicting injury with varying degrees of lethal intent and awareness of motive. Adolescent suicide is caused by many factors. First, many of the young people in american society are experiencing a very unstable period in trying to find an identity, establish goals and define their role in life. There are physical changes which include exploring their sexuality, wide mood swings along with a wide variety of transitions. For example, the transition from junior high school to high school, when the individual is moving from childhood into adulthood and thoughts of their future become a reality. These changes are all normal for any adolescent, but unfortunately many youths do not handle these changes well.

There are certain characteristics common to all suicide victims. These victims feel depression due to some loss. Along with their depression, feelings of helplessness, despair and worthlessness are involved (Pretzel, 1972). More girls attempt suicide, but more boys actually succeed, due to the way the suicide is attempted by each. Girls tend to take pills or cut their wrists. Boys, on the other hand, choose guns or hanging as their mode of action. The suicidal person may be either verbal or non-verbal, direct or indirect in their communication. The highest potential for suicide occurs when the person engages in non-verbal and indirect behaviors (Farberow, 1967).

According to Waltzer (1980) there are numerous signs that will help a counselor recognize a potentially suicidal client. They include:

1. Previous suicide attempts. This is the top predictor and includes attempts made by family and friends.

2. Sleep disturbances. This can increase the intensity of depression.

3. Definiteness of a plan. The more definite the plan, the

more serious the intent.

4. Reversibility of the plan. Time span is an important consideration. The use of a gun or jumping from a high place is irreversible most of the time. If the client is planning to take pills, then there is a chance the plan can be reversed.

5. Proximity of others. Does the client express the belief that there is no significant other who will try to prevent the suicide attempt.

6. Giving possessions away. The suicidal individual is likely to give prized possessions away.

7. History of alcohol or drug abuse. There is a greater risk if the client is dependent on drugs or alcohol.

8. A history of previous psychiatric treatment or hospitalization.

9. Availability of resource and support systems. Does the client realize these systems exist.

10. Willingness to use resource and support systems. Suicidal clients will cut-off communication with people making the attempt more severe.

Counselors need to be aware of these characteristics in order to help the potential suicidal client; thereby, reducing the incidence of adolescent suicidal victims and the number of surviving adolescents who will be grieving the loss of their friend.

Adolescent Bereavement

Bereavement for a friend of a suicide victim is extremely difficult. Close friends of a suicide victim go through the same emotions as the victim's family, often in a more intensified fashion. The suicide victim is often closer to their friends than their family because friends have been their support system (Street, Saunders and Valente, 1982). The death of a peer forces confrontation with one's own death. It is especially frightening for youth, since it taps into an adolescent's fears about the future and his/her inability to deal with adulthood (Gordon, 1988). It is often difficult for the adolescent to cope with the stigma, rejection and disillusionment that accompanies a suicidal death if he/she does not have an established identity or a good self-image. When a friend commits suicide, feelings of guilt, complicated by a feeling of inadequacy due to their limited exposure to death as faced by an adolescent (Valenti & Sellers, 1986). It is often difficult for an adult to pick up on signs of bereavement in adoloscents because the signs of grief are the same as those of normal adolescence.

Bereavement includes grief, which is the emotional response to death. Mourning is the social expression of bereavement. Anytime a personal loss occurs one experiences grief and mourning. Grief allows the bereaved to change their self-concept and make transitions to new stages of identity

(Osterweis, as cited in Valente, Saunders & Street, 1988). The length of the grieving process is different for each individual.

Kubler-Ross (1969) has helped identify the stages of grief for survivors. The emotional and physical responses of grief will vary from person to person and each individual situation. These stages of grieving include: denial, anger, guilt, bargaining, depression and acceptance.

Denial: After a death, the adolescent denies that the loved one has died. This stage of grief is strongest when death occurs suddenly.

Anger: The adolescent feels anger that a loved one has died.

Guilt: The adolescent feels that they could of done something different to prevent the death of the loved one, or feels they may be at fault for the death.

Bargaining: The adolescent feels if they live differently or promise to make a perfect life for the future, the dead person will come back to life.

Depression: Depression becomes part of the adolescent's life because they can not accept the death of the loved one.

Acceptance: The adolescent accepts what has happened and discovers there is life after the death of a loved one.

Many of these stages may be experienced at the same time and in any given order. Grief and mourning provide the survivor with an opportunity to accept their loss and make changes in their inner world. Grieving also allows the survivors to search for the meaning of their own lives. All individuals must proceed through the grieving process, without which they would experience a continual feeling of loss with no hope of ever finding a purpose in life.

Theory and Technique

After a suicide it is important for the counselor to intervene immediately because the grief process begins after the survivor is notified of the sudden death. If the counselor is able to help the adolescent express their feelings as soon as possible, the adolescent will deal more easily with death in the later stages of grief. There are three theories used when dealing with suicide and bereavement. Roger's use of empathy and unconditional positive regard offers a safe environment in which the bereaved individual will feel understood and in which he/she may begin the grieving process (Patterson & Eisenberg, 1982; Rogers, 1951). Empathy is important for the counselor to possess in order for the bereaved adolescent to express their emotions. Unconditional positive regard, allows beareaved adolescents to experience their emotions, which will include, anger, loneliness, depression, guilt, helplessness, and the individual's sense of loss. The counselor's unconditional positive regard enables him/her to accept their feelings as a normal reaction to the grieving process (Kaplan, 1979; Doyle 1980).

The Gestalt approach is another positive way to help the adolescent accept the death of a friend. The Gestalt theory places importance on enhancing an individual's awareness of their thoughts, feelings, and sensations about death. The theory avoids glorifying the act of suicide, yet avoids ignoring what will be missed about the suicide victim. It also stresses that the individual learn to express his/herself in ways that might be more personally nourishing. (Alexander & Harman, 1988).

In order for adolescents to express their feelings, several Gestalt techniques may be implemented. One such technique would be to give the bereaving individual an opportunity to address the suicide victim by use of the "empty chair technique". This procedure allows the bereaved adolescent an opportunity to say "good-bye" to their deceased friend and begin to resolve any "unfinished business" that the grieving individual may be experiencing.

Another helpful technique would be to ask the individual to think about the suicide victim for one minute. When time is called, the individual is provided with crayons and a large sheet of paper and asked to express their feelings using colors, lines, shapes and symbols (Oaklander, as cited in Alexander & Harman, 1988).

A final helpful technique could be asking the individual to carry on a dialogue between their hands... the right hand representing the deceased individual, the left hand representing the bereaved adolescent. This technique allows a dialogue that will help adolescents get in touch with their feelings of anger and guilt, allowing the healing process to begin (Hughes, 1988).

The Existentialist use of support groups is a technique in which social support can help the bereaved adolescent modify the long-term effects of the death of a friend. Studies have shown that the adolescent who had high social support systems after the death of a friend were significantly less depressed than those who did not (Gray, 1988). After a suicide, counselors need to approach friends of a bereaved adolescent and discuss with them ways of which they might be helpful. If a group format is used, this support from peers will provide help in a more familiar context than would be true for the direct counselor-adolescent relationship (Balk, 1983).

According to Gray (1988) the counselor needs to invite the bereaved to attend group sessions and give them information about the group. A time and place that is convenient needs to be established and a maximum size of five to nine adolescents arranged. After the first session, participants decide what topics they would like to discuss. For example, they may choose to discuss their feelings of anger and guilt, memories about the deceased, or deal with one's own fears about death. It may also be helpful to have the group work with structured exercises in order to encourage discussions. Such examples may be:

1. Having group members write down questions that they might be too embarrassed to raise in group; then the leader will introduce those questions to the group.

2. Group members may be asked to write a letter to the deceased expressing any thoughts or feelings that were unexpressed at the time of the death (Gray, 1988).

3. An "unfinished business" exercise with the deceased which can allow the adolescent to explain what they may be sorry for in relationship to the deceased (Kaplan, 1979).

Summary

Since little research has been done concerning the bereavement of adolescents due to a peer's suicide, and because the rate of adolescent suicide is steadily rising, it is this author's belief that concern needs to be placed on the effects suicide has on surviving adolescents. Counselors need to be prepared to deal with adolescent suicide and the bereavement of friends. Programs need to be implemented in schools and communities to educate adolescents about suicide. Also support needs to be offered to the bereaved when the suicide of a peer does occur, in hopes that a future suicide can be prevented.

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USE OF BEHAVIORAL TECHNIQUES IN CONTROLLING STEALING BEHAVIORS IN CHILDREN

by

Donna Aratani
Oregon State University
Department of Counseling

Use of Behavioral Techniques in Controlling Stealing Behaviors in Children

Stealing is an act which is widely prevalent, centuries old, recognized in all cultures, incident at every age, occurs in any class, or creed, yet is poorly understood" (Renshaw, 1979, p. 9). Specifically, nonconfrontative stealing, theft that does not involve direct contact with the victim and occurring more than once within a 6-month period has been constantly linked with later academic failure, psychopathologies, and delinquency. The _Diagnostic and Statistical Manual of Mental Disorders-III-Revised_ (DSM-III-R) (American Psychiatric Association (APA), as cited in Miller & Klungness, 1989) ranks nonconfrontative stealing as the most discrminative diagnostic feature of a childhood conduct disorder. In addition, Robins (as cited in Williams, 1985), in a classic longitudinal study, reported that a history of thefts in childhood is a good predictor of later antisocial acts.

Despite the seriousness of this crime, the act of stealing has not been closely studied in isolation but is usually included under the heading of delinquency. Traditional intervention methods such as parental or educational lectures, advertising campaigns, and criminal prosecution have had little or no effect (Williams, 1985).

DSM-III (APA, as cited in Miller and Klungness, 1986) defines nonconfrontative stealing as "a persistent pattern of conduct in which either the basic rights of others or major age-appropriate societal norms are violated" (p.24). Most professionals in this particular field of study have no other criteria, except for the DSM-III guidelines, to determine what constitutes stealing behavior and when this behavior begins to violate age-appropriate norms.

However, for the purposes of this paper, a stealer will be defined as "a child who is between the ages of 6 and 12 who has been caught stealing nearly once every three or four months" with the judgement that this behavior has persisted for at least one year (Patterson, as cited in Miller & Klungness, 1986, p. 24).

Kohlberg's (as cited in Pettijohn, 1989) cognitive theory of moral reasoning gives a developmental perspective proposing how children reason about right and wrong. According to Kohlberg's model, children under the age of ten generally are in Level I, preconventional morality. This is a period in which moral reasoning is based mainly on expectations of rewards and punishments. The individual conforms to society's norms in order to receive rewards. At this level, "rightness or wrongness of the act is not as important as "getting even" or "doing it" for the sake of gratificationn or excitement (as cited in Olson, 1981, p. 195).

In Level II of Kohlberg's moral development, conventional morality, moral reasoning is based on conformity and social standards. A person behaves according to the expectations of family or peer groups, regardless of the consequences. They may feel, "Everybody's doing it, so why not me" (p.195). The behavior, depending on group norms, can be positive or negative. By the time an individual is 13-years old, he or she is likely to be at Level II.

According to Kohlberg (Pettijohn, 1989), most people never reach Level III in their moral development where thinking is based largely on personal standards and beliefs. The individual at Level III is also concerned with individual rights and democratically decided laws.

A general overview of Kohlberg's levels of moral reasoning can help counselors and teachers address stealing behaviors according to the individual's level of moral reasoning. However, it is important to realize that levels of reasoning are not always related to chronological age; instead a child must be assessed in terms of his/her developmental age group.

Techniques

The majority of treatments for stealing behaviors in the past twenty years have taken a behavioral orientation. Thus, this paper will focus on the different techniques coming from a behavioral perspective. The techniques to be discussed are: aversive contingency management, positive contingency management (including group contingencies), self-control procedures, and parent training approaches.

Aversive Contingency Management Approaches

Punishment techniques, scolding, threatening, lecturing, and physical force are the most common aversive methods employed to control a child's stealing behavior. Parents and teachers report that these aversive methods rarely bring about positive results (Switzer, Deal, & Bailey, 1977). They are usually ineffective because there is, most times, a long delay between the act of stealing and the actual punishment.

Covert behavior modification techniques have been used to treat stealing behavior. In this procedure, an imagined stealing incident is followed by an imagined aversive consequence. For example, a client may be told to imagine himself being caught and punished for stealing immediately following the imagined act of stealing. Guidry (1975) used this technique when treating the compulsive stealing of a young man in his twenties. At the end of treatment, the stealing behavior had dropped from twice per month to near zero and it remained constant after a 10-month follow-up. According to Guidry, the client indicated that he still got urges but stated, "I feel a sense of responsibility that I didn't feel before" (p. 169). Cautela (as cited in Miller & Klungness, 1986) was also successful with this technique when working with an adolescent juvenile delinquent who was involved in many cases of car stealing.

Another adversive contingency technique is an overcorrection procedure used by Azrin & Wesolowski (1974) to decrease the mealtime stealing behavior in institutionalized severely and profoundly mentally retarded adults. It was designed in such a way that the thief was required to give the victim an item identical to the stolen one in addition to returning the stolen item. This procedure was compared with the more commonly used "simple correction procedure" (restitution) where the thief is only required to return the stolen item. The overcorrection procedure reduced thefts by 50% on the first day, by 75% on the second day, and there were no thefts by the fourth day or thereafter. This method was more rapid and effective than the restitution procedure and according to Azrin and Wesolowski, it should be applicable to the nonretarded. I believe that an overcorrection procedure would be more effective than the simple restitution procedure with nonretarded school-age children. From my teaching experiences, I usually witnessed youngsters feeling that it wasn't such a "big deal" to return something that didn't belong to them in the first place. There was no major loss on their part. However, it is my opinion that they would become upset if they were required to give an additional item as a result of their stealing behavior. When applying the overcorrection procedure in a classroom setting, there may be a problem if the stolen item is of great monetary value. Would I have the right to ask a child to buy a twenty dollar watch in addition to returning the stolen one? Some legal issues would need to be investigated as well as possibly dealing with many irate parents.

Positive Contingency Management Approaches

Two types of positive reinforcement contingency procedures have been commonly used to treat nonconfrontative stealing with individuals and groups. In differential reinforcement of other behaviors (DRO), reinforcement is contingent upon the removal of a stealing behavior. In differential reinforcement of alternative behaviors (DRA), reinforcement is contingent upon the completion of a desirable behavior (e.g. work completion and class participation) (Miller & Klungness, 1986).

Wetzel (1966) did a case study utilizing a DRO procedure to treat a 10-year old male. This child had a 5-year history of stealing and destructive behavior and was placed in a children's home. As part of the treatment, a daily check was made by staff members to see that he possessed only his own belongings. The companionship of a staff member he admired was made contingent upon the possession of his own things. Stealing was eliminated in 90 days.

A similar study was done by Rosen & Rosen (as cited in Miller & Klungness, 1986) where a combination of the DRO and response cost procedure (token system) were used to treat a 7-year old boy enrolled in a special education class for behavioral disorders. He frequently had another classmate's belongings in his possession. The subject's possessions were marked and checked every 15 minutes. He was rewarded with praise and tokens for only having the marked items. A reprimand and fine were given when unmarked items were found. Stealing was reduced and this reduction was maintained during 31 days of follow-up.

In comparing the above two studies, I prefer the use of a relationship with a significant other (as in Wetzel's study) as a contingency as opposed to materialistic items. The choice of a reinforcer, however, is very crucial and it is important for that person to be able to make the relationship contingent on a specific behavior. In this case, not stealing.

Alhough the use of materialistic items work well with so many children, it can become extremely costly for counselors and teachers. Also, other children may resent the child who is receiving all of this attention or may even act out to elicit some recognition of their own. This was a controversial issue in the school where I last taught. There was some discord between colleagues who did and didn't use materialistic reinforcers. Some children may expect to receive "prizes" from all teachers and counselors and will not perform unless they receive otherwise. The techniques described above were done with special needs students.

Two other studies using a group contingency adaptation of these procedures were employed in a normal classroom setting. All students in the classroom were rewarded for appropriate behavior. Brooks & Snow (as cited in Williams, 1985) combined a DRA and response cost procedure to stop classroom stealing by a 10-year old box. Tokens were given on work completion and class participation and were exchanged for an individual reward and extra free time for the entire class. If there was an occurrence of stealing, however, class free time was lost. The group contingency was effective and the child's work and participation improved. There were no recurrences of stealing.

Switzer, Deal, & Bailey (1977) present a well-controlled study addressing the needs of a teacher who had concerns over a number of nonconfrontative stealing episodes in her classroom. A comparison was made between using a lecture method and a DRO group contingency with three second-grade classrooms. During the lecture phase, the class received a lecture from their teacher stressing the negative aspects of stealing. During the group contingency phase, the class was given extra free time for no acts of stealing and there was a loss of free time if stolen items were not returned after a teacher prompt.

In the above study, measures were taken to insure the absence of any negative peer pressure. It is my opinion that pressure cannot be completely controlled. However, I do feel that some pressure applied by peers would aid in putting a stop to classroom stealing. I am also in favor of utilizing group contingencies in the classroom but would need to work on developing a more reliable method of detecting theft. Many children may fail to report a theft if the extra free time is seen as being more valuable than the stolen item.

The above four studies show how differential reinforcement methods can be used as effective treatments in reducing stealing. Although DRO procedures have been studied more extensively than DRA, the latter would be more appropriate for elementary-aged students in the classroom setting because specific alternate positive behaviors are targeted for reinforcement.

Self-Control Approaches

A major barrier for successful interventions is the delay between the stealing behavior and a follow-up of appropriate consequences. The use of a self-control procedure can shorten the delay between the act of stealing and its consequences

(Henderson, 1981; Stumphauser, 1976). Self-control techniques such as relaxation and self-instruction are new in treating childhood stealing. These methods provide a means to foster intrinsic independent functioning in children (Roberts & Dick, as cited in Miller & Klungness, 1989).

Stumphauser (1976) used a combination of self-control and family contracting to treat a 12-year old girl with a 5-year stealing record. During the 15 sessions, the girl was taught to use self-monitoring, self-evaluation, and self-reinforcement statements whenever she was faced with real or imagined situations of stealing. These individual treatments were supplemented with parent consultation and training. A family contract was drawn up which reinforced non-stealing behavior and bonuses were given when stealing was stopped for weeks at a time. Stealing was eliminated in 6 weeks and follow-ups at 6, 12, and 18 months showed no further stealing incidents.

Henderson (1981) combined relaxation training and self-instruction techniques in treating ten children ranging from 8-15 years old. According to Henderson this approach would only be applicable to a client who wants to stop stealing and who has at least one adult in his environment who is willing to help him. In 7 years, Henderson (1981) has met only one thief who did not want to stop.

Henderson's technique is referred to as individualized combined treatment (I.C.T.) because it attends to both the internal (emotions and feelings) and the external environment of each individual thus "recognizing the essential unity of the organism" (Wolpe, as cited in Henderson, 1981, p. 232). Two main aspects of this technique is self-control of the internal environment and adult control of the external environment.

Self-control. During the relaxation training, the client is asked to imagine himself in a setting where he is tempted to steal and then he is instructed to :"Stop, relax, and walk away" (Henderson, 1981, p.233). The client is also expected to practice this strategy outside the clinic.

External control. This part of the treatment focuses on monitoring "not stealing" behavior in order that it may be appropriately reinforced. The child carries a notebook which is known as the "not stealing" diary where records are kept of the individual's daily whereabouts. These records are checked by an adult at various stopping points throughout the day.

There is no evidence to show that these individuals would not have stopped stealing without I.C.T. treatment. However, the results show this technique was beneficial. Eighty percent of the subjects stopped stealing with I.C.T. treatment and have not stolen since (Henderson, 1981).

Henderson (1981) purports that self-control methods can help children learn decision-making skills and become independent learners. These methods also can easily be applied in a classroom setting. However, I am not confident that it would be beneficial for students who are not able to cognitively reason at a level where adequate problem-solving skills need to be accomplished. I.C.T. requires the child to be strong-willed and have the diligence to work at correcting his problem. Overcoming the stealing behavior greatly depends on the individual to rely on himself and not on others. Therefore, I feel that students who are not self-motivated will not respond well to this technique.

Parent Training Approaches

Many researchers have stressed the importance of addressing the family system as a means of changing the conditions that originally influenced the child to steal. Children may best be understood by viewing their behaviors as products of the interactions among their environments and their own personal characteristics (Conoley, 1987).

A behavioral parenting approach developed by Gerald Patterson and his colleagues has been recently adapted to treat nonconfrontative stealing in children (Patterson; Patterson & Gullion; Patterson, Reid, Jones, & Conger, as cited in Miller & Klungness, 1986). In addition to directly treating a child's stealing behavior, this technique focuses on modifying the behavior of parents. To alter a child's behavior, parents are taught to observe, collect data, and apply different types of reinforcement combined with response cost procedures. Adaptations were made because it was found that parents of stealers were not very responsive to their child's positive or negative behaviors. This distancing and portrayal of acceptance and leniency of the stealing act may have contributed to the continuation of stealing by their child (Reid & Patterson, 1976).

As a result of these findihgs, extrinsic reinforcement were used to increase the motivation and participation of the parents in the program. Parents were given a weekly salary and assured that their child would not be put in jail. Daily phone contacts were also made during the initial phases of the treatment. Parents were also taught how to track and identify stealing incidents. This insured that consequences were applied to all actual or suspected acts of stealing. Reid and

Patterson (1976) concluded, in the results of seven case studies, that these parental interventions can lead to significant reductions in the rate of stealing.

Although studies have shown the effectiveness of these parental interventions, I personally am not comfortable with the idea of utilizing extrinsic means (parent salary) in motivating parents to participate in the program. I would instead like to see the implementation of more parenting workshops in the schools. These workshops would be structured in a way so that parents and children may work on developing better relationships with one another as well as building positive self-concepts.

Conclusion

Four different behavioral techniques in treating stealing behaviors have been discussed: (a) "Aversive management approaches" uses negative reinforcement to stop stealing. Specific methods include covert sensitization and overcorrection procedures; (b) "Positive contingency management approaches" such as DRO and DRA methods are applicable to both individual and group contingencies; (c) "Self-control" techniques require less adult supervision but are most beneficial for self-motivated children; and (d) "Parent training approaches" and their importance must not be overlooked. Also, family interventions need to become an integral part of any school treatment program.

Although studies presented in this paper have not all been specifically targeted for children between the ages of 6 and 12, I personally feel that all techniques and strategies utilized may be adapted to this particular age group. All studies also have some practical uses in the school setting.

In the literature review, I noted a discrepancy regarding the intensity of consequences following a stealing behavior. Hampton (as cited in Henderson, 1981) "shows that there is a positive correlation between the severity of punishment and the frequency and seriousness of re-offending." D.S.W. has also claimed that once a child has appeared in a

Children's Court he has a greater chance of reappearing there (as cited in Henderson, 1981). "Not being apprehended at all gives the child the best chance of not re-offending" (Haney & gold, as cited in Henderson, 1981, p. 231). On the other hand, Renshaw (1979) states, "An important method of handling stealing is to stress that the sooner the stealing is discovered and dealt with, the more successful will be its inhibition. To be caught the first time with full consequences and shame is the critical learning factor" (p.11). I see myself leaning more towards Renshaw's views, but the word "shame" does not compliment my values of respecting the feelings of fellow human beings. I also find it troubling to know that D.S.W.'s statistics show Children's Courts as not being effective in controlling stealing behaviors.

After reviewing the extensive findings by many researchers on the various behavioral techniques used to control stealing behavior, I feel that the parental training approach would have the greatest impact on children because I believe that the home environment is the most influential in sculpting a child's behavioral patterns. However, more effective techniques than were presented here need to be reviewed in order to help foster parental nurturing.

From a systems theory perspective, I would like to see some studies combining family, school, and community interventions in helping to treat stealing behavior in children. Perhaps if youngsters can witness their significant others and environmental influences joining forces to help them, they will become motivated and more responsive to treatment. In the near future, I hope more schools will begin to recognize the family unit as being more of a significant factor in controlling the stealing behavior in children.

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